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Speech / Discours

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Speaking Notes
for the
Honourable Diane Marleau
Minister of Health



Speech from the Throne Debate
First Session of the Thirty-fifth Parliament
of Canada
Ottawa, January 28, 1994

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Our approach is straightforward -- we intend to improve the current system, not by some radical shift in the fundamental principles, but by the development of creative solutions to the problems that have arisen as the system has grown and evolved.

I call this approach -- *creating value, while maintaining values*.

That means that we will stick to the five principles of the Canada Health Act which have served Canadians so well over the past quarter century.

Let me repeat what those five principles are, since many members are new to this House, and because the principles are so important to the debates which inevitably will ensue over the months ahead.

First, **universality** -- Canada's health system must be for all Canadians.

Second, **portability** -- the benefits of our system must be available wherever in Canada our residents choose to live.

Third, **comprehensiveness** -- it must include all medically necessary services.

Fourth, **accessibility** -- no Canadian should be deprived access to the health system, and that means no "user fees". This Government cannot accept any measures which amount to a "tax on sickness".

And fifth, **public administration** -- the health of Canadians represents an important national asset and it must be administered overall on a non-profit basis by the public sector.

Even with these principles firmly entrenched, there is still considerable opportunity to improve the overall health system.

And since the health system is such an important national asset, it is essential that we bring Canadians together to work cooperatively to renew and enhance it for the future.

There is considerable agreement that we need a more cost effective and efficient health system and about what it should look like in the future. However there is little agreement about how we get there.

These are not easy questions and they require a national dialogue to generate the necessary consensus to improve the health care system. This is the thinking behind our announcement to create a National Forum on Health to be chaired by the Prime Minister of Canada himself.

The Prime Minister's personal involvement signals just how important we consider this issue to be for our national well-being!

I know that some Canadians have grown tired of all the consultations, special task forces, and other mechanisms established by the previous government to examine issues *ad nauseam*. We know Canadians appreciate their health care system, we know they strongly oppose user fees, and we know that they are looking to the federal government to continue to play a major role in the health system.

Let me assure you, Mr. Speaker, that this government is listening and acting upon these messages.

We do not want to duplicate existing mechanisms for cooperation and collaboration. Instead, we wish to create a focus for a national discussion on a health strategy for Canada which encompasses all the various viewpoints, including those of the ultimate users.

We understand that the Federal Government is not the only government responsible for the health of Canadians. We cannot and will not go it alone. That is why I will be discussing this important initiative with my provincial colleagues when we meet in Ottawa on February 8th and 9th.

I want to emphasize at this point that I am fully aware that health spending represents on average 30% of provincial budgets and that provincial governments have made very significant efforts to come to grips with challenges in this area.

This exercise will provide an opportunity to highlight the issues and the difficult challenges all governments face and it will also help improve the climate for change.

But governments, at all levels, cannot and should not bear the full responsibility for the health of Canadians. The medical profession, health care providers, the research community, the pharmaceutical and other health-related industries, employers, employee organizations, and consumers have important roles to play.

We also hope that the National Forum on Health will raise the knowledge level of Canadians on a number of issues, many within their own control, and educate the general population on the possibilities as well as the challenges.

Yes, Mr. Speaker, individual Canadians also have a role to play. Because while health is a collective responsibility, it is also an individual responsibility.

We are each our own personal health managers.

Many of our personal choices will determine the extent of our health and our quality of life.

By bringing together all the participants, from governments to individual users, in this renewal exercise, I truly believe our health system can gain without pain.

One area where I believe that there is substantial potential for collaboration is in the field of health awareness. Right now, all levels of government are engaged in awareness programs on such issues as substance abuse and HIV/AIDS. Improved coordination among federal, provincial and territorial program areas would certainly lead to more efficient messaging and give all Canadians greater return on their health investment.

Where I live in Northern Ontario the health needs and the available services may vary from those in downtown Toronto or Montreal or Vancouver. But a good idea developed in Sudbury or Moncton or Red Deer can be of value for all Canadians wherever they live. And there are plenty of good ideas out there in every region of Canada.

Let me give you a few examples. For nearly 20 years there has been a Federal/Provincial/Territorial Committee on Group Purchasing of Drugs and Vaccines whose efforts have resulted in real savings to our health care system. When one member changed the method of supply for Measles, Mumps and Rubella vaccine from dealing directly with the supplier to bulk purchasing through this group, they realised a 68% saving.

Three Ontario schools, including Laurentian University in my own constituency, are establishing undergraduate programs in mid-wifery which are expected to save money by reducing the number of pre-natal doctors' visits while providing pregnant women with quality care in the community.

Unique to Quebec are the Local Community Service Centres which provide locally-based health care in an effective and client-friendly manner.

All of these programs are good examples of what I call "spending smarter". By placing existing innovative programs within a more coherent framework, and by bringing together creative people with those who must administer and those who must use the system, I believe that we can generate even more ideas which can add value to the overall health framework in Canada.

International comparisons show us that we do not have to spend more to produce a better overall health system for Canadians.

For example, thousands of Canadians are sent every day for medical treatments of various kinds. But how many of those treatments are really evaluated to see if there are effective and better alternatives? I believe that there is tremendous potential for savings in our health system by doing a proper evaluation of what currently exists.

I believe that women's health requires special attention. One of our specific initiatives, as outlined in the Red Book and in The Speech from the Throne, will be the creation of a **Centre of Excellence for Women's Health**.

Traditionally, the health system has been regarded as "gender neutral", but most adult women and adolescent girls can give vivid examples of how the system has a strong male bias.

The women's health issue is an area which urgently needs more research -- as the recent Forum on Breast Cancer so poignantly highlighted.

Let's face it. There are basic biological differences between women and men, and gender does have an impact on the distribution of many diseases across the population.

And yet, many clinical trials of drugs and other treatments underrepresent women in their samples or exclude women completely. Not only is it bad policy, it's bad medicine.

Women do have special conditions, from osteoporosis to menopause, and they merit equal attention, from research to treatment to care and prevention.

We have to move the health system forward in this regard, not to the detriment of anyone's health, but to the benefit of everyone's health.

Again, we have many ideas in this area, from the establishment of specific research goals to the development of programs for groups such as immigrant women and aboriginal women whose particular needs have not always been adequately served by the health system.

Any discussion of women's health must establish the connection between violence in the family and the overall health of the woman, her children, and others living in the household. My colleague, the Minister of Justice has overall responsibility for this critical area, but my Department continues to play an important role with respect to family violence prevention through building partnerships with non-governmental organizations and the provincial and territorial governments.



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Speaking Notes
for the
Minister of Health,
The Honourable Diane Marleau



Canadian Medical Association - 127th Annual Conference
Montreal, August 15, 1994

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Ladies and Gentlemen,

"Our health care system is one of Canada's proudest achievements. Based on the belief that every Canadian has a right to receive the care he or she needs when sick, regardless of personal circumstances. It is an affirmation of Canada's commitment to human dignity."

Almost a year has passed since we published those words in *Creating Opportunity*, our Liberal Red Book. They were not placed there as pious sentiment, nor as an election promise -- to be forgotten soon after the votes were counted. They were placed there because some issues are fundamental. Some issues define a government's attitude and approach across the wider spectrum of public policy. Some issues are a litmus test for intentions and actions.

Health is one of those issues. Ensuring reasonable access to high quality health care is one of the fundamental expectations that citizens have of governments in Canadian society. Ensuring conditions that promote and sustain health is another.

But can governments live up to those expectations anymore? Can we deliver what Canadians want, with the taxes they are prepared to pay? Some are asking those questions. Some of you, in this room, today, are asking those questions. Our government believes we can.

Canada's physicians and your national organization, the Canadian Medical Association, know full well the strains on today's health system and the people who make it work. You know the added pressures, the increased controls, the increasing concern about how best to continue to provide what Canadians need.

You share that concern with many other people. In my travels across Canada, I have spoken with hundreds, perhaps thousands, of people who wonder about the future of Canada's health system. Like you, they know that the days of easy budgets and simple answers are over. They know that pumping more money into the system is not an option. But they know that simple budget paring is no response either.

Canadians are challenging all governments, all partners in our health system. They are challenging us to find answers -- **answers** that respect the genuine needs of people, **answers** that are consistent with financial realities and **answers** that result in the right care, in the right place, by the right person, at the right time.

I firmly believe those answers exist. I believe that with careful thought, planning and effective spending, we *can* respond to the challenges that face us. We *can* continue to meet the priority Canadians attach to good health and our universal health system.

Today, I want to share my approach to renewing Canada's health system with you. I want to tell you about the federal government's role in shaping our health system for the future. Above all, I want to assure you that this government is dedicated to a process of renewal that has guided the principles of the *Canada Health Act*, a belief in results, and a commitment to partnerships. The Canadian Medical Association and the physicians of this country are among the most important of those partners.

I began my remarks with a quote from the Red Book. Its commitments in the field of health make a starting point for my description of our activities. For example, we promised to create a prenatal nutrition program. We were convinced that babies who get a healthy start in life do better than those whose mothers ate poorly during pregnancy.

Three weeks ago, I announced the **Canada Prenatal Nutrition Program**. It is a comprehensive approach that will support local programs that provide nutrition supplements and counselling to pregnant women. We expect it will help cut the number of low birth weight newborns from the current, and unacceptable, level of 21,000 a year.

We promised to make women's health needs a real priority. For example, we have taken action on breast cancer. I am pleased that the CMA is working with us on the Steering Committee on Breast Cancer Care and Treatment Guidelines.

To deal with the broader questions of women's health, soon we will provide details of our support for Centres of Excellence for Women's Health. These centres will be dedicated to making every program, policy and practice in the health system more sensitive to the needs of women. They will focus on how we can better address the health concerns of women such as the alarming rise in lung cancer among women resulting from increased tobacco use.

The work of the centres will complement the efforts of my department in areas such as drug and medical device regulation, research and health promotion.

The needs of Canada's Aboriginal peoples formed another Red Book priority. In the not-too-distant future I look forward to announcing a Head Start Program. It will enable urban Aboriginal communities to meet the physical, social and spiritual needs of their children.

To succeed fully, each of these initiatives demands that we address health in a comprehensive and results-oriented way. Each illustrates the challenge of health system renewal facing all governments -- how to address new priority areas where potential benefits are great, how to meet legitimate on-going needs, and all the while restrain overall health spending in order to limit taxes and encourage economic growth.

Some things are already clear. Every government is dealing with the fiscal constraints of today in its own way, but this government knows that the route to fiscal sanity in our public sector will not be through knee-jerk actions directed at our health care system, or the people who make it work.

The people who make up our health system are not a cost, but an asset. Physicians, nurses, other professionals, and the thousands of people in related health occupations are not a drain on the system. You *are* the system. By its very nature, health care is labour intensive. All the evidence I have seen so far shows that the people within the health system are committed to its renewal.

As individuals, and through organizations such as the CMA, physicians are playing an active and caring role as we tackle the issues and pressures facing health in Canada. You have recognized that our health system must and will evolve.

You have chosen to act as agents of change to strengthen that evolution. In that context, your contribution is both appropriate and welcome. I see that contribution at the level of individual practices and health care settings, in the community and on a provincial, territorial and national basis.

One issue that deserves attention is ensuring that the right numbers of physicians are in place, where they are most needed. As you know, we face imbalances not only in practitioner numbers between large cities and rural or remote areas, but also in different fields of practice.

But what is the right response? I believe that we must develop national physician resource management strategies that prevent the trend to parochial treatment of new physicians, and those seeking to move between provinces. We cannot build a stronger country, or a better health system, by raising barriers. We cannot address the health needs of underserved areas by forcing people there against their will. We can find better ways.

Looking to the future, I am glad that the CMA is at the table in our work with the provinces to examine integrated health human resources planning. It is through this kind of process that we can replace ad hoc attempts to address personnel issues with something more comprehensive and more appropriate to the interests of all Canadians in need of care.

These human resource issues are just one aspect of a renewal of the health system based on common values, priorities and results. That means, in addition to addressing the questions of "who practices," and "where," together with physicians we have begun to look more closely at the "how" and "why" of medical treatments.

The need to ensure that medical choices have outcomes that are medically and financially appropriate has spurred us towards the development of clinical practice guidelines.

The Canadian Medical Association has spearheaded the formation of the National Partnership for Quality in Health as a vehicle for developing guidelines based on real analysis. The government of Canada has provided financial support for this work and, more recently, became a full partner in an exercise that physicians lead.

In a similar vein, the Canadian Task Force on the Periodic Health Examination has earned a reputation around the world as a leader in assessing the value of preventive medical procedures. Since 1979, the Task Force has made recommendations to help health professionals and planners address critical aspects of managing health costs and treatments effectively. Our discussions with the CMA on the Task Force's forthcoming Canadian Guide to Clinical Preventive Health Care is another example of our shared focus on what works best.

Still, in the end, they are guidelines. They find their meaning in the decisions of thousands of physicians every day across Canada. They provide the information that allows you and your colleagues to make more informed prevention and treatment choices -- information we believe you are putting to use.

All these examples of cooperation are typical of the commitment to finding answers across the spectrum of health issues that we hope to see from the **National Forum on Health**, another Red Book commitment.

We know the process for renewing health care in Canada must rise above decisions made in annual government budget processes and isolated decisions made in response to specific issues.

We recognize, as you do, that Canadians face a number of challenges that will influence the kind of health care they will receive in the future. There is the impact of technology... of new drugs... of aging... and emerging possibilities thanks to research and innovation.

Some elements of these trends demand immediate attention. The Federal/Provincial/Territorial Conference of Health Ministers will continue to be the major intergovernmental decision-making body on health matters as we deal with current issues and look ahead. The federal government can and does play an active role in the health sector. We intervene in many ways through funding, research, health protection, public health intelligence, national standards and health promotion.

Next month in Halifax, I will be discussing with my provincial and territorial counterparts how best we can work together to improve the health of Canadians and at the same time ease the financial pressures we all face.

But governments don't have all the answers. A system that provides services to everyone, deserves diverse input as we sort out priorities for the future and strive for a longer-term national vision. I am confident that advice will come from the work of the **National Forum on Health**. The members of the Forum will engage the public and the health community in a dialogue that gets at the key questions facing the system. Let me say here that the Prime Minister and I welcome the participation of the provinces and territories on the Forum.

We envision a wide-ranging workplan for the Forum. We expect to see national and regional conferences, working groups and a wide array of public participation efforts.

We anticipate an open process of consultation that reflects the attachment all Canadians feel towards health issues, and the commitment to finding real solutions. I believe the **National Forum on Health** represents an excellent opportunity to address the future of health in Canada in a comprehensive and open way.

The Forum may help contribute to the trend towards a broader vision of health that I as Minister of Health, believe is fundamental to renewal. That is:

- ◆ one that recognizes the physical, economic, social and environmental determinants of health;
- ◆ one that achieves a better balance between health care and health promotion, prevention and protection measures.

But I should stress that the role of the Forum is not to go back to square one. For our part, we are going into this with a firm sense of the principles that currently govern health care in Canada.

Universal, portable, comprehensive, accessible and publicly administered -- the five principles in the *Canada Health Act* are the benchmarks for our health care system. They are standards that the federal government is determined to uphold. But upholding them takes more than rhetoric. It takes a willingness to face situations in which those principles might be undermined in important ways. That is why our government has addressed, and will continue to address, specific and serious breaches of those principles with individual provinces: to protect the right of all Canadians to health care services when needed, at no extra cost.

Canada's health care system translates the values of justice and care into reality. Indeed, it defines us as Canadians.

Upholding those principles also takes money. That is why our February budget gave the provinces the financial stability to continue with the reform of their health systems. As organizations like yours have pointed out, no province or territory can make the changes our health system needs in the absence of some firm notions about future funds. We have responded.

Universal medicare has contributed to the quality of life we enjoy in Canada. It has helped us develop a health system that ranks among the world's most efficient and equitable. It is a program we will defend.

As we undertake this renewal process and as we deal with the day-to-day issues of health care in the '90s, let us keep three facts clearly in mind.

The first is that Canada is not alone in this process. All developed countries are wrestling with many of the same questions that we are. Many of the issues, such as the need to control costs, are ones we face. Others, such as the wisdom of ensuring universal access to health insurance, are ones we resolved a long time ago.

The second fact is that, even with all the challenges it faces, even among the alarmist claims of "medicine in crisis," Canada's health care system is still strong and working very well. We do not have "cash register medicine" in this country and we are not going to.

The third fact is that health system renewal is within our grasp to achieve. There are conflicting interests and perspectives. There is the stress between what is and what could be.

Change, especially when it involves something so critical and so cherished as our health care system, can generate fear. But as the futurist, Alvin Toffler, has written:

"Our moral responsibility is not to stop the future, but to shape it ... to channel our destiny in humane directions and to ease the trauma of transition."

The task before us will not be completed simply or smoothly. But it is an essential one. The health consensus among Canadians demands that we act. Canadians expect us to find ways to continue the traditions of care and excellence that have long marked Canada's health system through new tools and new approaches. I am determined to do my part and I look forward to your help in making that system a reality.

Thank you.



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Speech / Discours

Speaking Notes
for the
Minister of Health,
the Honourable Diane Marleau

7th International Congress on Obesity
Toronto, August 20, 1994



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Canada

Members of the International Organizing Committee, distinguished guests and delegates . . .

It is my pleasure to bring greetings on behalf of the Government of Canada and to welcome the 7th International Conference on Obesity to Toronto. I hope you will find time to take in some of this city's many fine attractions and to take advantage of our Canadian hospitality.

If you stroll along Toronto's streets, or streets in any of our cities, you will see that obesity among Canadians is all too prevalent -- 27% of women and 35% of men in Canada are overweight.

Like other industrialized nations, too many citizens of this country pay a price for our prosperity. Genetic considerations aside -- for the moment -- we are to a great extent products of our affluent society. It is a tragic irony that when we see evidence of poverty on our television screens or in our communities every day, many in this country suffer from an overabundance of food, and as a consequence face health risks due to their weight.

High-fat diets -- and weight problems associated with them -- are major risk factors for cardio-vascular diseases and for some types of cancer, the leading causes of death in Canada. We know, too, that weight control is essential to reducing the risk of hypertension and diabetes and assists in the management of arthritis.

At the same time, it is important to have a realistic understanding of what is an appropriate range for healthy weights. Thinness, weight control and commercial concepts of beauty are priorities of popular western culture. Societal pressures have made weight loss predominately a women's issue -- focused more on fashion than on health -- with girls and women as the primary targets of weight-loss marketing strategies.

Concerns about the safety, competence and integrity of some weight-loss programs prompted my department to convene a Task Force on the Treatment of Obesity, which reported in 1991. In response to its findings, Canada now has guidelines to ensure that:

- ◆ those for whom weight loss is inadvisable are not accepted into treatment programs;
- ◆ those who receive treatment are not exposed to dangerous regimens; and,
- ◆ consumers are treated with dignity.

As Canada's Minister of Health, I am pleased that my department is involved directly with this issue because of our regulatory responsibility for weight-loss products. As well, Health Canada has created a **Women's Health Bureau** to advise on the effectiveness of health policies in terms of responding to women's health needs.

In the results of the *Survey on Smoking in Canada*, released on Thursday, I was encouraged to see that smokers were smoking less today, and that only three per cent of former smokers resumed smoking "to control weight". This shows us that Canadians realize that smoking is not the answer and that there are healthy ways to maintain weight.

Further, I would like to draw your attention to our outreach programs on disease prevention and health promotion. In 1991, for example, Health Canada launched **VITALITY**, an initiative to help Canadians achieve healthy weights by focusing on health-enhancing behaviours. **VITALITY** takes a holistic approach, encouraging healthy eating, active living and positive self and body image through public education, community action and education of health professionals.

Canadian Guidelines for Healthy Weights -- promoting the use of the body mass index -- have been introduced to help people break away from rigid ideas about body shapes or sizes and to help themselves to more satisfying lives.

Canadians are becoming more aware of the controls they can exert over factors contributing to obesity and the positive impacts they can have on health.

Nowhere is our progress more apparent than in the area of heart health -- with mortality rates due to coronary disease and stroke reduced by half over the past two decades -- largely as a result of healthier lifestyles and better treatment.

Through the Canadian Heart Health Initiative, a truly national effort which unites the federal and provincial health departments, the Heart and Stroke Foundation and 300 other partners, we have been able to bridge the science/policy gap in cardiovascular disease prevention.

We have also compiled the Canadian Heart Health Database, the largest of its kind in the world. All ten provinces have completed surveys to identify the prevalence of different risk factors, including obesity. I am delighted some of its ground-breaking data will be presented to this Congress.

Our efforts to date also demonstrate that public education works. Canada's last Health Promotion Survey shows that millions of Canadians report they have improved their diets, quit smoking, learned to better manage stress and generally adopted healthier lifestyles.

This is part of our broader vision of health which recognizes the physical, economic, social and environmental determinants of health and achieves a better balance between health care and health promotion, prevention and protection measures.

Clearly, there are numerous opportunities for further cooperation in the area of health promotion. Many of you here today contributed to the **Victoria Declaration on Heart Health**, a global blueprint for disease prevention.

That document makes a powerful point: we already have the scientific know-how and the capacity to significantly reduce this disease. It is up to us -- as scientists, practitioners and policy makers -- to help individuals to bridge the gap between knowledge and lifestyles.

I am well aware that this work is underway within this community of scientists and health care professionals dedicated to the study and treatment of obesity. I want to recognize the Canadian members of the International Organizing Committee and to give special mention to Dr. Claude Bouchard of l'Université Laval who will deliver the "Willendorf Lecture" tomorrow.

I also commend the International Conference on Obesity for structuring a program that brings scientists and clinicians together for the first time. I encourage you to capitalize on this rare opportunity to exchange ideas and share new information. In Canada, we believe in -- and are committed to -- the power of such partnerships.

Working closely together, I have every confidence you will build on your substantial progress to enhance the quality of life for all, as you unravel the many unsolved mysteries of obesity.

I wish you every success as you undertake this important task in the days ahead. Thank you.



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Speaking Notes
for the
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**Canada's Health Care System: Medicare for All
One Voice – A National Conference on
Protecting and Improving Canada's Health Care System
Montreal, September 8, 1994**

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Monique Bégin put in place the five key criteria for our national health insurance system and abolished user fees and extra billing. Health insurance in this country must be -- and is -- universal, comprehensive, accessible, portable and publicly administered.

In a number of informal meetings with Canadians, you have confirmed the continuing relevance of these criteria in 1994. All Canadians expect our health insurance system to be universal and accessible. All Canadians want health care benefits to be comprehensive and portable. And not least important, all Canadians want government to administer the system.

In other words, Canadians believe -- and this government agrees -- that the fundamental principles laid out in the *Canada Health Act* are as important today as they were ten years ago!

This government is and will continue to be committed to the *Canada Health Act*. The Red Book is crystal clear on this matter. My actions since becoming Minister of Health are testimony to this unwavering commitment.

In a meeting last May, representatives of seniors' organizations told me that you appreciated the stance I had taken on extra billing. You thanked me for the firmness I showed when British Columbia contravened the *Canada Health Act*. This stance came easily for me because I too remember what it was like before medicare.

I have seen and lived two-tiered medicine. So have you. We all remember well the days when we had to pay our medical bills right at the doctor's office. We all remember how difficult it was for some people to pay and how often it influenced people's decision to see the doctor when they were ill. Canadians should never again be faced with the uncertainty, the inequity, and the pain that comes with a private health care system.

I also say "no" to user fees. User fees discourage some older Canadians and those with limited financial resources from seeking necessary health care. They represent a false economy.

I have undertaken to address outstanding *Canada Health Act* issues in a consistent, coherent and coordinated manner. For example, I have put in place a mechanism to examine the out-of-country portability provisions. Before taking unilateral action on this matter, I want to give this consultation process a chance to work. The matter is on the agenda of the federal/provincial/territorial ministers of health's meeting next week.

Canada's health system is a critical resource for this country, for without it, we would be a much poorer nation, in terms of both compassion **and** competitiveness. One system for the rich and one for the poor is simply unacceptable. Your support is critical to ensure Canada does not develop a two-tier health system.

I obviously have a professional stake in seniors' issues. But, like you, I also have a personal stake. Some of you know my mother, Yvonne LeBel! I am proud to say that she was one of the pioneers in the seniors' movement. She urged others such as André Lecuyer from the Assemblée des aînées et aînés francophones to become active on seniors' issues. Some of you worked with her when she was president of the Fédération des aîné(e)s francophones de l'Ontario.

Like many of you, my mother was part of the generation that sculpted our present health care system. She believes -- and she taught me well -- that some compromises are not acceptable. I share the conviction of my mother's generation that the dismantling of the *Canada Health Act* would be one such compromise.

In short, I know on a personal, as well as a professional level, what the *Canada Health Act* has meant, and still means, to Canadians. We must ensure it remains intact.

My government also has a second commitment -- a commitment to helping Canadians to help themselves.

Canada spends less per capita on health than the United States. In the United States, 37 million people do not have medical insurance -- a full 10 million over and above the total population of Canada. Despite this fact, Canada is experiencing challenges which are common to all Western societies.

We face changing and escalating needs and wants; the push and pull of evolving health demands is forcing us to take a hard look at old patterns, preserve what is valuable and discard what is not. Governments have to respond with new and creative approaches. In terms of health objectives, we must focus on outcomes and relinquish our loyalty to outdated service delivery systems.

For example, there are many ways to get to Montreal -- by air, car, train, limousine or foot. Some are more cost efficient than others. Some are more comfortable. And some are faster. There are some that we simply wouldn't consider. But we have to consider costs and benefits of the various options.

As a country confronting its health system issues, the Liberal government also wants to reach its goals in the most comfortable and cost-efficient fashion possible that benefits Canadians.

One solution is to place more emphasis on home and community-based care. It is a comfortable option for us because it is in keeping with what we know seniors prefer: to remain independent, to stay in their homes, close to friends and family. We must take care that gaps do not develop as we move from an institution-based to a community-based model. We must be realistic, have an open mind and make the right decisions.

Another solution is to stress health promotion and prevention -- to adopt more holistic approaches to health. For example, Canadians can become involved in their own care as it relates to prescription drug use.

Too often, physicians and emergency rooms across Canada have seen the disastrous effects of drug misuse and overuse.

Since becoming Minister, I have directed our limited financial resources geared to seniors to cost-effective, value-for-money and targeted initiatives. Projects that promote self-care and self-reliance. Projects that are managed with and by seniors because I believe that they are best able to tell us what their needs are.

A new mind set requires that we accept personal ownership of our health care needs, relying less on "quick fixes" and more on lifestyle changes. Those of us with a stake in health issues -- and that pretty much includes all Canadians -- must call upon consumers, providers of health care, and governments at all levels to develop the necessary support systems.

We must pull together community resources to get the most value from our tax dollars.

For my part, I have worked hard to maintain funding stability for federal transfers to the provinces. Providing a predictable fiscal environment is one of the most important contributions the federal government can make to the renewal of Canada's health system.

A third commitment of this government is to help seniors who require additional support to remain independent. The aim of seniors' programs in my department is to enhance seniors' independence and to prevent or delay dependence.

Women are among the most vulnerable seniors. The average lifespan of a woman is longer than that of a man; so women are more likely than men to exhaust their resources during the course of their lifetime.

Unlike older men, the majority of older women do not remarry after the death of a spouse. More often they live longer and live alone. Many have low-incomes, with government pensions as their only source of income. In the Red Book, my government made a promise to create **Centres of Excellence for Women's Health** aimed at effective and equal treatments of women's health issues in the Canadian health care system.

With that goal in mind, we will establish **Centres for Excellence in Women's Health**. These Centres will promote a better understanding of women's health concerns. The Centres will allow us to create strategies to meet priority needs. And they will help us to customize policies, programs, and practices to the special needs of women.

Canada has been twice ranked by the United Nations as one of the best countries in the world in which to live. That reputation derives in large part from our national health system -- and from the priority that we place on ensuring full participation in Canadian society.

To make it easier for seniors to get information and to participate, we have combined most of the aging and seniors-related programs of my department into one directorate. In this way, we have created an effective single focal point for seniors' programs and services. The new Seniors Directorate is the point of contact for seniors' groups and individuals.

The National Advisory Council on Aging is also playing a key role as an advocate for seniors' interests. The Council advises me on every issue related to the aging population and the quality of life of seniors.

The fourth commitment of this government is to find a Canadian solution to the renewal of Canada's health care system. To this end, we are establishing a **National Forum on Health**.

The **National Forum** will be asked to develop a vision for Canada's health system in the 21st century. This vision must recognize the physical, economic, social and environmental determinants of health. Moreover, it must be capable of achieving an acceptable balance between health care and health promotion, prevention and protection measures.

Too often in the past, so-called consultations have been like firework displays. Large-scale. Short-lived. Flamboyant and expensive. More sparkle than general illumination. Our **National Forum on Health** will be more than that. It will be an ongoing process, not just one spectacular event. It will focus on medium and long-term issues.

This Forum will be a meeting of Canadians who share a profound concern for our country's well-being. And it will be an inclusive process, involving people in all regions of the country. It will not be a country club event, a gathering of opinion leaders in a glitzy setting.

Twenty citizens with a sound knowledge of our health system -- whether as volunteers, professionals, or consumers -- will participate in the Forum. Forum members will establish and participate in working groups and in national and regional conferences. The public will be given many opportunities to participate. Reports and discussion papers will document the findings of the Forum so that all interested parties will stay informed.

I know that we can count on the members of One Voice and other seniors organizations to help the government to realize all its commitments. You have already demonstrated your awareness of the issues and your concern for seniors at risk. In the coming months and years, we will be asking you to help us identify and reach out to seniors with special needs.

The solutions that you develop at this conference will continue to evolve over time, as you test them in practice. Once you are convinced that you have a good working document, I invite you to present it to the Forum.

In the meantime, I will bring the results of this conference to a November meeting in Winnipeg with my provincial and territorial colleagues who are responsible for seniors.

I have answered the central question of this conference from the perspective of a federal government minister committed to the health interests of seniors.

I want to assure you that I will continue to be a voice for seniors -- in Cabinet and in government caucus. I will continue to be an advocate for your concerns.

In closing, I want to challenge you to answer the question on a **personal** level. After all, commitment is not about organizations. Commitment is about people -- who hold strong personal beliefs and are willing to work hard for what they believe.

When you conclude this three-day conference, you will leave this building as individuals -- committed to making the proposed solutions work.

So I challenge you. Consider how best to continue involving organizations and governments. Consider how best to involve individuals -- yourselves and others -- in personal ownership of health issues and personal responsibility for practising positive health behaviours.

We do face many uncertainties in the years ahead. But as English writer Margaret Drabble once said: "*When nothing is sure, everything is possible.*"

There will always be uncertainties in change. Let us embrace this opportunity to shape the health system of the future, not stop it. Canada's health care system translates the values of justice and care into reality. Indeed, it defines us as Canadians.

In that spirit, I wish you the best of success with your conference, and I look forward to receiving a summary of the results.

Thank you.

News Release

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**Speaking Notes
for the
Minister of Health
The Honourable Diane Marleau**

**Challenges of Case Management in a Changing World
Second International Conference
on Long Term Care Case Management**

**Canadian Home Care Association and
the American Society on Aging
Toronto, September 17, 1994**



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Ladies and gentlemen,

I am happy to be with you tonight for this conference on the management of long term care.

On behalf of the Government of Canada, may I express a warm greeting as well to our American friends and guests.

The Canadian Home Care Association and the American Society on Aging are doing significant work.

I am especially impressed by how you have drawn attention to the importance of long term care in today's changing world.

We are all acutely aware of just how fast our world is changing:

- ◆ the rapidly aging populations of the industrialized nations;
- ◆ technology's breathtaking march forward, which brings us wonderful new possibilities ... and troubling ethical dilemmas;
- ◆ the adjustments needed to our health care systems, in order to respond to an increasing demand and tight financial resources.

You feel the impact of these changes more than most. With your experience, knowledge and accomplishments, you help society adapt to the reality now taking shape.

In a very real sense, you are pioneers, charting a course toward a new understanding of health care.

Through your efforts, the barriers that have always separated institutions from the community and the home are coming down.

Your cooperation with health professionals and para-professionals is an example to be followed. Indeed, that partnership spirit must be at the heart of our renewed health care system.

In your "continuum-of-care" models, you have successfully combined the latest in scientific and medical developments with a personalized service that responds to the different needs -- whether psychological, emotional or physical -- of individual human beings.

Your comprehensive approach has shown that home care can benefit everyone: the people receiving care, their families, their communities, and our society at large.

I find your successes very encouraging. They reflect the philosophy behind the renewal of Canada's health care system.

The difficulty before us now is threefold: there is the staggering pace of change, the ever escalating demand for health care and the limit on our fiscal resources.

These are daunting obstacles, so we need creative alternatives, tested expertise and a lot of goodwill.

The search for innovative solutions involves everyone.

This conference allows us to pool our information, to share our knowledge and to move forward together.

Your discussions will no doubt shed much needed light on new ways to achieve more independence, more dignity and less suffering for long term care receivers.

I strongly believe that in the field of long term care, important progress can be made through cooperation and belief in a common cause. By strengthening our alliances, we will gain even greater benefits.

One plus one can equal more than two. That is why I am so pleased that the Canadian Home Care Association and HomeSupport Canada are joining forces.

Together, you will be in a stronger position to help shape the future of quality home care in this country.

Even more important, by eliminating duplication, you will assure the most effective and efficient use of our health care resources.

My friends, partnership involving national organizations, professional organizations and governments are essential to this field.

We must actively encourage all our citizens to become involved in the planning and development of our health policies.

Canadians, especially those who receive long term care and their loved ones, must be full participants in the management of their own health care. Their concerns and insights must always be reflected in our choices.

We must always remember to involve the ultimate stakeholders, the people who receive care and their loved ones.

By engaging health care users in discussions and activities aiming at their maximum physical, mental and social well-being, we all win.

In the field of home care, family and friends make a pivotal contribution. Thanks to their strong personal bonds, members of the informal care network help you ensure that patients receive the highest quality of treatment.

To renew Canada's health care system, we need mutual trust and a genuine commitment to change at all levels of the community and at all levels of government.

Through the **National Forum on Health**, we urge Canadians to get involved in the renewal of our health system.

We want insights into the real life challenges confronting real people.

We want to hear about community-driven answers to those problems.

The Chrétien Government is fully committed to creating a modern health care system; one that maintains the high quality, the compassion and care of the current system, while responding to the challenges of the next century.

There is no question that we can -- and we will -- reform our health system without compromising the principles of the *Canada Health Act*.

That determination and political will was strongly expressed by Health Ministers in Halifax this week.

We will maintain a publicly funded system available to all based on the stated of their health, not based on their ability to pay.

My vision for Canada's health care system is one in which individuals and organizations work together to deal with complex issues, putting people first -- always above process and politics.

I am delighted that your conference reflects those goals.

One thing is sure: long term care with its many components -- medical treatment, home care, respite care -- will be a key element in our agenda of reform.

It is important to focus our thoughts and discussions on one paramount goal: to enhance the independence and dignity of those we serve.

When they created our health care system, our forebears faced difficult challenges, and emerged victorious. I am confident that through hard work and ingenuity, we shall do the same.

Like most Canadians, I believe we have the best health care system in the world. Indeed, it defines us as Canadians.

We should always keep in mind that our health care system translate our common values of compassion and care into reality. This will allow us to approach the renewal of Medicare with compassion, serenity and maturity.

I wish you a very enlightening conference. Millions of people are grateful for your good work.



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Speech / Discours

Speaking Notes
for the
Minister of Health Canada
the Honourable Diane Marleau

The International Federation of Gynaecology and Obstetrics
40th World Congress
Montreal, September 25, 1994



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I am delighted to open this 40th World Congress of the International Federation of Gynaecology and Obstetrics and to welcome you on behalf of the Government of Canada.

Canadians are proud to play host to this illustrious international gathering and to be able to showcase the marvellous city of Montreal. I hope you will find time to explore this wonderful city.

In Canada, women play a central and vital role. Canadian women are increasingly becoming a force to be reckoned with in every aspect of the social, economic and political fabric of our nation.

The ripples of our influence are felt in many ways. Our contributions affect the quality of life of our families, our communities and our country.

The changing status of women is perhaps one of the most significant social changes shaping Canada today.

However, there is ample evidence that health care systems -- in this country, as well as in many other countries -- have not given great attention to women's health issues. The Government of Canada is committed to not just ensuring, but also **enhancing** women's health and well-being.

We must become more sensitive to women's needs within the broader context of our everyday lives.

The Government of Canada has launched a number of initiatives aimed squarely at improving the health status of women and children. More and more we are focusing greater attention on sexual and reproductive health. The recent conference in Cairo also focused international attention on this and several other priority issues.

And, we are equally committed to addressing female cancers, nutrition, chronic and degenerative diseases, women's mental health and, women's occupational and environmental health.

As Minister of Health, I was proud to announce this summer two new programs for women.

Through the **Canada Prenatal Nutrition Program**, the federal government will promote the development and growth of healthy babies. It is our goal to reduce the incidence of low birth weight among newborns.

To do that, we must improve the health of pregnant women. The program will offer supportive, community-based services to provide food supplementation, nutrition and lifestyle counselling -- such as smoking cessation -- and related information to pregnant women at risk, particularly teenage mothers.

Our **Women and Tobacco Initiative** -- part of our national **Tobacco Reduction Demand Strategy** -- is another program area geared specifically to the interests of women. We know that smoking is the leading cause of premature death among Canadian women, with more than 15,000 women dying each year as a result of smoking cigarettes.

Through research, public education and the development of women-centered programs with a female-specific approach, we want to increase the number of women who become and remain tobacco-free.

An example is our recently launched **Anti-Tobacco and Health Lifestyles Program** -- which targets women with low income and low education, women raising children on their own, as well as young and Aboriginal women.

Investing our health dollars in these areas pays lifelong dividends that can begin as early as birth. Increasingly, we are concentrating our efforts on health promotion and illness prevention.

The initial avoidance of harm, rather than intervention by the health care system to remedy a situation after the fact, is now a major element of all our health policies.

The arguments for this approach are as much ethical and social as they are economic. Creating opportunity for all our citizens is the top priority of the Canadian government. We know Canadians can only seize those opportunities when they enjoy optimal health.

To ensure women's health receives proper attention, it is essential to clarify the issues and develop the data respecting the health risks faced by women. For this reason, I will very soon make an announcement concerning the **Centres of Excellence for Women's Health program**.

In recognizing the differences between the sexes, women's concerns will finally be brought to the forefront in such areas as health research and clinical trials.

The need to focus our efforts specifically on the experiences of women is a good reason to establish **Centres of Excellence**. These Centres will allow us and the health system to create strategies to respond to women's **unique** needs; to help us customize our policies, programs and practices to reflect the priority health interests of women -- today and tomorrow.

Some of the pressing concerns that I have already identified are the needs of women facing breast cancer. This year, some 17,000 Canadian women will learn they have become part of the statistics -- the one in ten who can expect to develop the disease at some time in her life.

Breast cancer research is a primary issue on the national health agenda. We are committed to identify and to support biomedical, psycho-social and prevention research to solve the mystery of this deadly disease.

Five **Breast Cancer Information Exchange Pilot Projects** across the Canada will help people make informed decisions about prevention, early diagnosis, treatment and all aspects of follow-up care.

Women with HIV/AIDS are also part of a health crisis that is a critical priority shared by many nations.

The Society of Obstetricians and Gynaecologists of Canada has just released **Practice Guidelines for Obstetrical & Gynaecological Care of Women Living with HIV** in collaboration with my department. I understand this important new tool for practitioners and care providers will be highlighted in a workshop during this congress.

Reproductive health is another critical component of our overall women's health strategy. We are particularly interested in the health and safety implications of reproductive technologies, as well as their ethical and social implications. Because, while primarily affecting women, use of these technologies has ramifications for the entire country.

A recently concluded Royal Commission on New Reproductive Technologies told us that these technologies require boundaries, accountability, a flexible and continuing response to emerging technologies.

New reproductive technologies have the power to fundamentally affect the future lives of all our citizens, particularly our children.

We believe these new technologies must be considered within a comprehensive sexual and reproductive health framework, an approach our government is beginning to develop in consultation with a wide range of shareholders. Continuous public discussion and input from many parties is required, including medical and research groups like your own.

This has been an exceptional year for international conferences devoted to the interests of women and families. First, was the designation of 1994 as the **International Year of the Family**.

In highlighting issues facing families today, the **International Year of the Family** strives to build stronger children and stronger families, objectives that closely mirror the philosophy of the Canadian government.

We are committed to safeguarding our most precious resource, our children. We value our families and communities as the source of our social stability and economic strength. Families truly are at the heart of our society.

In recent weeks, the International Conference on Population Development agreed on a program of action that will help the world community to achieve population and development goals over the next twenty years by dealing constructively with population growth.

Canada endorses the progressive recommendations resulting from the Cairo conference. We are encouraged by the recognition that improving the conditions of women and empowering them with choices will help to build a better world.

This congress of the International Federation of Gynaecology and Obstetrics will further advance the promotion of the health and well-being of women and girls.

Canada respects and appreciates your proven leadership in education, research and program development in the field of female health.

International conferences such as this take us another step farther in a long continuum of progress. And progress is clearly critical. Because, ultimately, women's health equals world health.

By drawing together our current knowledge ... assessing the gaps in our understanding ... and identifying opportunities for further advancement ... we are building bridges for women, health systems and governments.

These strategic alliances hold out the hope of a day, not far off, when all citizens of this world are afforded true equality.

I leave you now to carry on your important work as you strive to achieve that goal. I wish you every success. Thank you.



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Speaking Notes
for the
Minister of Health,
the Honourable Diane Marleau

Fédération de l'Âge d'Or du Québec
Quebec, September 25, 1994



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I would like to begin by thanking you for having invited me to this lovely gathering.

I am proud to be your "*Partner in Action*". I sincerely hope that all of you will be my partners in the projects I would like to talk about today.

For the past two days, you have been discussing ways to facilitate understanding, communication, sharing, in fact we could even speak of a degree of connivance between seniors and young people.

What a wonderful idea!

All around us, we see broken families, families rife with division. This situation affects all generations.

In this the *International Year of the Family*, it is important that we rediscover the contribution made by the elderly members of our families, and to cement the bonds that link the generations.

As your president, Mr. Lapointe, mentioned, and I quote: "*Despite the mechanisms in place for consultation and communication, many seniors feel more isolated than ever before and many young people find it increasingly difficult to be listened to by adults.*"

The members of FADOQ want to help overcome that isolation, and create a dialogue between young people and those who are not so young.

The 300 activities organized by FADOQ's various groups to mark these fifteen days of "intergeneration" impress one with their variety and the creativity that went into their design.

- ◆ Seniors from Golden Age Clubs and schoolchildren worked together to pick fruits and vegetables left behind in the fields and donated the food to Montreal Harvest.
- ◆ Elsewhere, people organized grandparent grandchildren olympics.
- ◆ Young people taught seniors how to use computers.
- ◆ Seniors visited a kindergarten to read fairy tales to the children.
- ◆ Others gave some old-fashioned cooking lessons to young people.

All of these initiatives prove that there are many ways for young people and seniors to learn together, to have fun together and to discover things together.

That is what I call real "complicity".

I am certain that each of those projects made a tangible contribution to bringing together the two generations, as well as helping them better understand each other. You went off the beaten path. You dared to try something new. For that you deserve our gratitude and our admiration.

Like you, we must all show daring creativity and tenacity. We must adapt to rapid social change. We must deal with diminished financial resources.

That is true for our seniors, whose life expectancy -- especially for women -- continues to increase, forcing them to redefine old age.

It is also true for our government, which must serve all citizens with increasingly limited means.

I was reminded of that concept of public service when I had the pleasure to speak with our friend, the Honourable Monique Vézina.

All Parliamentarians have a great deal of respect for Mrs. Vézina for all the work she has done to advance the cause of seniors. We all owe her a great deal and it is our firm intention to build on her accomplishments.

In order to make further progress, we need to state our principles, set out our priorities and begin the essential process of reform. That means making intelligent choices and targeting our interventions very strategically.

It is in that spirit that I would like to discuss four fundamental commitments our government has made to seniors.

These commitments, which were clearly outlined in our Red Book, are the following:

- ◆ protecting the fundamental principles of the *Canada Health Act*
- ◆ urging Canadians to take responsibility for their own health
- ◆ providing seniors with the support they need to maintain their autonomy

- ◆ renewing our health care system while taking account of the values and priorities of Canadians

Twenty years ago, an influential Minister from Quebec, Marc Lalonde introduced the concept of responsibility for health care shared between the federal and provincial governments.

Later, Monique Bégin -- another dedicated, energetic and effective minister -- gave our national health insurance plan its five fundamental principles: it is comprehensive, universal, accessible, portable and publicly administered.

That these principles are the bedrock of our system is accepted unconditionally at both the federal and provincial levels. Indeed, the provincial and territorial Health Ministers reiterated their support for these principles at our meeting in Halifax ten days ago.

Our government will therefore continue to be very vigilant to ensure that these principles are adhered to in every part of the country.

I sincerely believe that our health care system reflects the values of compassion, sharing and equity that we all hold so dear. Furthermore, it gives our country a definite competitive advantage against other industrialized nations.

Our health care system must remain accessible to everyone. It must not be limited by how much money you have, but by how much care you need.

Secondly, we want to urge Canadians to take responsibility for their own health.

Medical progress, longer life expectancy, the growing importance of **alternative therapy** are all developments that force us to reconsider our practices, our approach to medicine. Increasingly, we are able to move away from a reliance on institutions and can choose the more human setting which focuses on the family and the community.

Like you, we believe that it is important to grow old while remaining healthy, to be autonomous, to remain in one's own home surrounded by family and friends.

That is why we are emphasizing the health promotion and preventive health care, homecare and community care.

We all know that good nutrition, regular exercise and a healthy lifestyle contribute to keeping us healthy through different conditions and at all stages of our life.

We are there to help citizens make choices that will maintain and improve the state of their health.

We support research in this area. We provide information to the public.

Among the many initiatives under way, we are conducting a very interesting experiment involving long-term care centres. Residents are being asked to participate in planning their own treatment, especially the aspect of prescription drugs.

Generally speaking, seniors consume a great deal of medicine -- some of it prescribed by their physician, some of it not. Also, they often make mistakes in following the instructions, which can have very serious consequences.

This problem has been reported in every emergency room in the country.

With adequate information and vigilant supervision -- by the patients themselves -- we will be able to avoid these all too common occurrences.

It is important to address health care issues with a comprehensive approach.

We urge people -- especially seniors -- to take advantage of every opportunity to remain active and healthy for as long as possible.

But when a person does need care, we must recognize the important role played by family and friends. Thanks to their close personal ties with the patients, the members of this informal care network can ensure that those who need it receive care that is of the highest quality.

It is crucial that we pool our community resources. That is the best way for us to help you stay healthy, maintain your independence and preserve your dignity. It is also, in our opinion, the most worthwhile way to invest the funds we receive from taxpayers.

Our third commitment involves giving special support seniors people who are in vulnerable situations so as to help them remain independent for as long as possible.

It is first and foremost toward these seniors that we want to target our efforts. We are making them our priority because their needs are more pressing and, in the current financial situation, we must channel our resources toward those who are in the greatest need.

We have noticed that, in the past, our health care system did not pay as much attention to women's health as it did to men's health. Not by design, of course, but simply because Medicine had not realized that there is a fundamental difference between the two.

It is to deal with that shortcoming that we are creating Centres of Excellence for Women's Health.

Finally, our government has committed itself to finding a Canadian solution to the challenge of renewing our health care system.

We have announced the creation of a **National Health Forum**. This forum will be made up of about twenty people, from all walks of life, who all share a deep understanding of our health care system.

The **National Forum** will look at what is at stake in the medium and long term in order to suggest a health care approach that responds to the needs of today.

This vision for the future will have to balance health care with health promotion, preventive health and health protection.

This process of renewal will involve all Canadians, who will be asked to come forward and participate in consultative activities.

My friends, as you can see I have many plans -- they are ambitious, and most of them will be difficult to accomplish. Nonetheless, they are all very interesting because they seek to improve the quality of life for a group of very deserving Canadians, seniors.

Of course there is a great deal of change in the air. Reform, review, study -- these are all very popular terms. They are also words which can sometimes scare people -- especially seniors.



I understand your concerns... I want to assure you today that, in all our decisions, we will always be mindful of you. We are here to serve you. It is possible that our services will change, but it will always be in order to better serve real needs. Always in your best interests.

I have a special attachment to the cause of our seniors because I had a good teacher on the subject; my mother, one of the pioneers in the francophone seniors' movement in Ontario.

She made me truly aware of the difficulties, the isolation and the distress that too many elderly people have to live with.

She helped me discover what an invaluable source of knowledge, experience and tradition seniors are, always reliable and always available.

By combining these great qualities with the energy, the sense of wonder and the unsinkable hopefulness of the young, we will overcome the great challenges of the 21st century with ease.

We can remember when there was medical care for those who could afford it, and precious little for everyone else.

Like me, you witnessed the birth of our national health care system. You contribute to making it even better.

That is why I am counting on you experience, your advice and your support during this period where our programs and services are adapting to the needs of our modern society.

I also hope that the collaboration we are sharing today will extend for a long time to come!



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Speaking Notes
for the
Minister of Health
The Honourable Diane Marleau

Women in Partnership:
Working Towards Inclusive,
Gender-Sensitive Health Policies
Ottawa, September 26, 1994



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Thank you, Claire Dubé, for your kind words of welcome. It is an honour to be introduced by someone who has worked so long and so hard to promote women's equality. It is an honour for me to share this platform with you.

Through the relentless efforts of women like you, and enlightened people within the corridors of power, attitudes are starting to shift.

I am pleased to be here with you today, to work in partnership towards more inclusive and gender-sensitive health policies.

I want to congratulate the Canadian Advisory Council on the Status of Women for bringing the issue of women's health to national attention. This forum will give us greater understanding of the complexity of women's health needs and the necessity of responding appropriately.

I am the first to concede we have not moved fast enough or far enough in addressing women's health concerns.

The fact the Prime Minister appointed a woman as the Minister of Health reinforces the importance of women's health as a national priority. In fact, we made a promise in the Red Book to make women's health a national priority, a promise I am determined to fulfil. Canadian women deserve no less.

Progress will only be achieved if we acknowledge present problems. And, as your ambitious agenda makes clear, there is no shortage of challenges.

Canadians take pride in our health care system, considered by many to be the best in the world. But if we scratch beneath the surface it is obvious not everyone shares equally in its benefits.

We are a society out of sync: we take for granted women are the primary caregivers to our families, our friends and our communities; yet, we overlook the factors that assure the good health of those same women.

We are still largely trapped by the widely-held perception that what makes us different is our biology. The traditional understanding of women's health has focused primarily on reproductive concerns.

Clearly, we need to look at women's health not just in relationship to men. It is not enough to simply compare life expectancy or the absence of disease as indicators of health.

We have to ask why women are often mis-treated or over-treated by the medical system. We need to question why the distinctive effects of chronic diseases on women, especially in later life, have been overlooked. We have to ensure that diseases exclusive to women are no longer ignored by the scientific establishment.

Increasingly, health practitioners and policy makers recognize that women's health fits into the broader social and economic context of our everyday lives. There is a growing understanding that the determinants of our health -- our individual and collective life experiences as women -- are distinct.

Just as important, we know that good health is more than just physical well being alone. Women have been saying, and society is starting to realize, that health must be addressed holistically -- encompassing our economic, emotional, spiritual and cultural well-being.

The Government of Canada has launched a number of initiatives aimed squarely at improving the health status of women and children. More and more we are focusing greater attention on sexual and reproductive health. The recent conference in Cairo also focused international attention on this and several other priority issues.

As Minister of Health, I was proud to announce this summer two new programs for women.

Through the **Canada Prenatal Nutrition Program**, the federal government will promote the development and growth of healthy babies. It is our goal to reduce the incidence of low birth weight among newborns.

To do that, we must improve the health of pregnant women. The program will offer supportive, community-based services to provide food supplementation, nutrition and lifestyle counselling -- such as smoking cessation -- and related information to pregnant women at risk, particularly teenage mothers.

Our **Women and Tobacco Initiative** -- part of our national **Tobacco Reduction Demand Strategy** -- is another program area geared specifically to the interests of women.

We know that smoking is the leading cause of premature death among Canadian women, with more than 15,000 women dying each year as a result of smoking cigarettes.

Through research, public education and the development of women-centered programs with a female-specific approach, we want to increase the number of women who become and remain tobacco-free.

An example is our recently launched **Anti-Tobacco and Health Lifestyles Program** -- which targets women with low income and low education, women raising children on their own, as well as young and Aboriginal women.

Investing our health dollars in these areas pays lifelong dividends that can begin as early as birth.

We realize the initial prevention and avoidance of harm, rather than health intervention, is essential if we are to secure personal health and safety. This is particularly true when we talk about substance abuse and sexual or physical violence. For this reason, harm reduction efforts of a gender-specific nature are critical components of **Canada's Drug Strategy** and our **Family Violence Initiative**.

The arguments for this approach are as much ethical and social as they are economic. Creating opportunity for all our citizens is the top priority of the Canadian government. We know Canadians can only seize those opportunities when they enjoy optimal health.

To ensure women's health receives proper attention, it is essential to clarify the issues and develop the data respecting the health risks faced by women. For this reason, I will very soon make an announcement concerning the **Centres of Excellence for Women's Health program**.

In recognizing the differences between the sexes, women's concerns will finally be brought to the forefront in such areas as health research and clinical trials.

The need to focus our efforts specifically on the experiences of women is a good reason to establish **Centres of Excellence**. These Centres will allow us and the health system to create strategies to respond to women's **unique** needs; to help us customize our policies, programs and practices to reflect the priority health interests of women -- today and tomorrow.

I can tell you now that I will soon appoint a national advisory group to assist me in refining a women's health framework and the terms of reference which will guide the work of the Centres.

Some other pressing concerns are the needs of women facing breast cancer. This year, some 17,000 Canadian women will learn they have become part of the statistics -- the one in ten who can expect to develop the disease at some time in her life.

We are devoted to the principle of self-care, respecting that individuals know their own self-interests. We also hold that individuals have responsible roles to play in their own well-being. The recommendations brought forward by the **National Forum on Breast Cancer** underscore the key roles women must play in deciding their own regimen of care of treatment and in determining the direction research should take into causes of the disease and its prevention.

Reproductive health is another critical component of our overall women's health strategy. We are particularly interested in the health and safety implications of reproductive technologies, as well as their ethical and social implications. Because, while primarily affecting women, use of these technologies has ramifications for the entire country.

A recently concluded Royal Commission on New Reproductive Technologies told us that these technologies require boundaries, accountability, a flexible and continuing response to emerging technologies.

New reproductive technologies have the power to fundamentally affect the future lives of all our citizens, particularly our children.

We believe these new technologies must be considered within a comprehensive sexual and reproductive health framework, an approach our government is beginning to develop in consultation with a wide range of shareholders. Continuous public discussion and input from many parties is required, including medical and research groups like your own.

Expanding our vision of health ... reducing our dependence on technology ... doing what works, involving a broader array of health providers ... self-responsibility ... and a greater emphasis on promotion.

These same topics match the key priorities identified as crucial to the renewal of Canada's health system and, ultimately, to our national well-being. They are particularly pertinent to women, but they are not just women's issues. They are society's concerns.

I believe health renewal holds out the best hope for resolving many of these problems because it is a positive response to the need for change.

I am confident we can confront the many opportunities and challenges constructively if we work together. I am confident that opportunities will be created by the **National Forum on Health** to learn about women's health.

We will not sit idly while we await the outcome of the renewal process, however. Work is already underway to make women's health a national priority.

Through the Centres, through consultations such as this symposium and the **National Forum on Health**, women's voices will be heard and heeded.

But I also want to assure you there are some things that will not change. I believe we cannot advance women's health interests without the certainty that the integrity of our national health system will be respected. That is why I have been such a staunch defender of the *Canada Health Act* and a constant champion of universality.

Though it will not always be easy, decisions have to be made. We need to keep the best and renew the rest.

As Canada's Minister of Health, I am committed to doing just that. I want to turn good intentions into good policy and common sense into common practice.

I expect your objectives and my larger goals for the renewal of Canada's health system will be complementary and mutually reinforcing. I find our agendas have much in common. Your priorities closely mirror the mainstream debate about the best ways to ensure health care is accessible and responsive to all Canadians.

I welcome your input as I undertake this task. I look forward to reviewing this symposium's final findings and recommendations. I wish you every success as you work toward your worthy goals in the hours and days ahead.

Thank you.



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Speech / Discours

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Speaking Notes
for the
Minister of Health,
The Honourable Diane Marleau

At a News Conference Announcing
Building Healthy Communities
Ottawa, September 26, 1994



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Canada

Vice Chief Gordon Peters, ladies and gentlemen, good morning and thank you for joining us for this important announcement.

Canadians have been shocked and disturbed at recent events taking place in some First Nations communities. Suicide rates among First Nations youth are about five times the Canadian average. Solvent abuse and alcoholism is reaching epidemic proportions in some Northern communities.

Many other key indicators provide ample evidence of the health disparities that exist between Aboriginal people and other Canadians. Infant mortality rates are about 48 per cent higher for First Nations and 180 per cent higher for Inuit than for the overall Canadian population. Despite a narrowing gap, life expectancy for Aboriginal people is still several years less than for the total Canadian population.

These disparities are unacceptable to Canadians, and it is clear that they must be more fully addressed. Additional and strengthened efforts are required if we are to achieve further improvements in First Nations and Inuit health conditions.

The federal government has recognized these problems and today, I am unveiling a new federal strategy that will help face the issues surrounding these events by enhancing and expanding existing health programs for First Nations and Inuit peoples. This strategy is entitled **Building Healthy Communities**. We will begin implementing it immediately in consultation with First Nations and Inuit at the community level.

We will address priority needs by strengthening our efforts and increasing funding in three critical areas -- solvent abuse, mental health and home care nursing. These have been identified as priority areas through our ongoing consultations with First Nations and Inuit communities and leaders.

In addition, we will enhance and expand the transfer of Indian and Northern health resources to First Nations and Inuit communities, at a pace to be determined in consultation with them.

Under the **Mental Health Crisis Management Program**, we will provide expanded, more comprehensive mental health services. We recognize that even this program will not eliminate all the mental health problems in First Nation and Inuit communities.

Nevertheless, it will offer training in crisis intervention to help communities to more effectively manage and intervene. Aftercare and rehabilitation services will support individuals and their families on the road to healing and recovery.

Solvent abuse is another serious problem for First Nations and Inuit people. To deal with this health issue, we will work with First Nations and Inuit communities to help provide a fuller range of initiatives, including early intervention, expanded residential treatment, training and research.

Our objective -- and our challenge -- is to reach and counsel people **before** they become chronic abusers. The focus will be primarily on youth, because this is where the problem is most common. This particular initiative will build on and tie into existing efforts of Health Canada, including the solvent abuse component of **Brighter Futures**.

It is clear to me that health programs designed and delivered by Aboriginal communities are more successful than those delivered by outside agencies. This has been confirmed by the World Health Organization in the international arena, and through our own experiences in Canada.

The continuation of the transfer initiative is extremely important because it will allow First Nations to plan, design and deliver community-based health programs that are culturally appropriate and that meet their specific needs. My department is also working with the Assembly of First Nations to include the **Non-Insured Health Benefits Program** in the transfer initiative.

Also under this strategy, we will provide support to coordinate on-reserve patient care to meet the needs of persons discharged from hospital and those with acute illness.

As you can appreciate in these times of fiscal restraint, the resources to expand these initiatives are scarce. We are well aware that the money that is available will not address **all** the problems.

But in addition to being fiscally responsible to Canadians, we must also be socially responsible. That means dealing with priority issues, such as Aboriginal health, in a controlled, well-managed and meaningful way.

A total of \$243 million, along with the current budget of \$ 81.5 million, has been allocated to the **Building Healthy Communities** initiative over the next five years. That is four times the current resources devoted to aboriginal health in these areas.

I am confident that these enhanced programs will improve our ability to work with First Nations to build healthy communities. Combined with the transfer and community-based health management initiatives, they will lead to innovative solutions that will help First Nations deal with, and hopefully prevent, crisis situations in the future.

This strategy provides concrete evidence that the Government of Canada is living up to commitments made in *Creating Opportunities* to work in partnership with First Nations to provide their communities with the tools and resources necessary to tackle the physical and mental health issues they face.

And now I invite Vice-Chief Gordon Peters to say a few words. I would be pleased to answer any questions you might have afterwards.



Speech / Discours

Statement
by the
Minister of Health,
The Honourable Diane Marleau



to the
Pan-American Health Organization

Polio Eradication in the Americas
Washington, D.C., September 29, 1994

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Mr. Chairman, Ladies and gentlemen,

It has been 13 years since the last reported case of polio in the Americas and 17 years in Canada.

Since 1949, 15,499 cases of paralytic polio have been reported in Canada. Two major epidemics occurred in the 1950s and many Canadians continue to live with the effects of polio. The disease has disappeared from our country but its effect on those who contracted it live on. Today, the victims of polio continue to need our support.

Our domestic efforts to eliminate polio have been complimented by our international work. Communicable diseases recognize no boundaries. We in Canada recognize that only through international cooperation can diseases such as polio be eliminated.

In partnership with the Canadian Public Health Association, the Government of Canada, through funding provided by the Canadian International Development Agency, has worked with the Pan-American Health Organization (PAHO) and a number of countries in the Americas to implement the expanded program on immunization.

It is worth noting here that 92% of the resources devoted to the program have come from the immunizing countries themselves. We are seeing the results of their commitment and our partnership efforts today.

The polio epidemic has also taught us some vital lessons about preparedness and prevention.

Our striking successes, first against smallpox, and now with polio, cannot lull us into complacency. Communicable diseases refuse to go away. Indeed, there is a growing global awareness and concern regarding the emergence of new and old microbial threats to health.

I would like to mention a few examples of Canada's attempts to enhance public health efforts and maintain our vigilance in this area.

In December, 1993, Health Canada convened an Expert Working Group to explore the problem of emerging diseases such as Hepatitis C and re-emerging diseases such as Tuberculosis. The long term goal was to ensure that Canada has state-of-the-art surveillance and control programs to meet the challenge of such diseases. The Group's recommendations stress the importance of global collaboration, and as the program progresses we will indeed share our experience with PAHO.

Our developmental work on population health intelligence is another initiative which may be of interest to other countries. Population health intelligence is the knowledge gained from surveillance activities and targeted investigations of disease occurrences and other risks to health.

It targets action against a broad spectrum of health risks including communicable diseases, environmental and occupational threats to health, as well as behavioral and development risks.

This approach seeks to strengthen and better integrate the current surveillance network to keep pace with emerging health threats.

The system draws upon a wide variety of national and international networks. We believe that such an approach will enable us to develop the appropriate tools to prevent and control a wide range of public health issues, both now, and in the future.

We are also pleased to participate in the proposed Pan-American Public Health Network. This electronic network will link countries and strengthen a wide range of public health programs in the Region of the Americas.

The earlier awareness of disease outbreaks will enable preventive and control measures to be quickly implemented. Also, the sharing of public health information will be enhanced. I am confident that such collaborative efforts will benefit all countries in the Americas.

Mr. Chairman, let me conclude my remarks by thanking the individuals who have shown such leadership in the fight against polio.

The PAHO initiative in the field of polio eradication is an excellent example of international collaboration on a major health issue. It is also a lasting testament to Dr. Macedo and Dr. Ciro de Quadros. My congratulations to them and to PAHO. Thank you.



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Speaking Notes
for the
Minister of Health
The Honourable Diane Marleau

Johns Hopkins University
Centre for Strategic and International Studies
Washington, D.C., September 30, 1994

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Canada

Thank you very much for that warm welcome. I am pleased to join you to discuss the Canadian health care system.

As the Minister of Health for Canada, it is my responsibility to oversee the operation of our health care system. I do not run the system -- that is the responsibility of my provincial counterparts. At the federal level, it is my job to see that the overall structure remains consistent with the fundamental principles that Canadians have chosen for their health care system. In other words, to ensure that the system remains true to the character of Canadian society.

Prior to becoming Minister of Health, I -- like every other Canadian -- was proud of our health care system. I was, and still am, proud of a system that provides quality care to **all** Canadians who require health care services. And it does this without point-of-service charges for medically-necessary care.

But now, as Health Minister, I have an appreciation for just how important our health care system is to us **as a nation**. And this is what I want to talk to you about today.

First, I would like to spend a few minutes describing the Canadian health care system. Perhaps I can dispel some myths for you.

Our Constitution assigns primary responsibility for health to the provinces and territories. For this reason, we actually have 12 distinct health insurance plans, each run by a provincial or territorial government. What makes it a "national" system is the federal legislative framework under which the provincial territorial plans operate.

This framework is contained in the *Canada Health Act*. The Act sets out five principles that provincial health insurance plans are obliged to meet to qualify for federal funding. I will describe these principles very briefly.

The first principle is **universality**. Every eligible provincial resident must be entitled to coverage by the provincial health insurance plan. Coverage is linked only to residency in the province -- not to jobs, nor to the payment of premiums.

The second principle is **comprehensiveness**. Provincial plans must provide coverage for all medically-necessary hospital and medical services.

The third principle is **accessibility**. Insured services must be reasonably

accessible and without financial barriers. This means, in part, that there can be no point-of-service charges for medically necessary services -- no extra-billing by doctors and no user charges in hospitals. Patients should not receive medical or hospital bills for insured services. The province pays the bills directly on the patient's behalf.

The fourth principle is **portability**. This is vital to a national system. It means that when Canadians travel or move across the country they continue to be covered by provincial plans. Coverage is also provided for Canadians who travel abroad.

The final principle is **public administration**. The health insurance plan must be operated on a non-profit basis, and must be accountable to the provincial government.

Adherence to these five principles gives the provincial systems a set of common features. This commonality is what makes our system "national." The Canadian health care system is not, then, a centralized, bureaucratic monster. It is a set of provincially-run, publicly-funded health insurance plans with common features.

There is no massive bureaucracy administering the system in the national capital. Indeed, there are fewer than 25 people administering the *Canada Health Act*. The system is run at the provincial level -- at a level closer to home for the average Canadian.

Physicians in Canada are not employees of the state. Most are in private practice. They simply bill their provincial plan, rather than dozens of private insurance companies.

Nor are hospitals owned by government. They are mostly community owned, non-profit, and operated by Boards of Directors. They receive their funding from the provinces, usually on a prospective, global budget basis.

Physicians in Canada have a high level of professional autonomy. Bureaucrats do not review cases and tell doctors how to practise medicine. Pre-authorization is not required. All insured services are covered by the provincial plan. It is the physician who decides what services will best meet the health needs of his or her patient.

Of course, physicians are subject to review by their peers through

provincial Colleges of Physicians and Surgeons. Government does not get involved unless there are billing irregularities of a magnitude or nature that require investigation. For example, an obstetrical billing for a male patient would be questioned.

In the Canadian system, both patients and physicians have choices. Patients are free to select any family physician or general practitioner, and some specialists such as paediatricians, obstetricians and ophthalmologists. Other specialists are accessible by referral.

Physicians, in turn, are free to choose the patients they care for. Only in emergency situations, are physicians required to provide treatment.

The existence of waiting lists is probably the most common criticism of the Canadian health care system. I am here to tell you that, **yes**, we do have waiting lists. But these waiting lists are not extensive. They exist only for some types of specialized tertiary services, many of which are elective.

I do not believe it is efficient or appropriate to have excess capacity in a health care system. We have a publicly-funded system and public dollars must be spent wisely and efficiently.

In Canada, we operate our health care system on the basis of medical need. Thus, those with the greatest need are treated first. Those requiring immediate care are treated immediately. Others with less urgent needs may have to wait days or weeks. Occasionally problems may occur, but provinces respond to correct excessive situations.

The quality of care and access to technology provided by the Canadian health care system are sometimes questioned. Canadians, I would like to point out, do not believe that they receive second-class treatment. And doctors and hospitals do not believe that they are providing second-class treatment.

Every major city in Canada can boast of a facility that is known for excellent care. For example, Sick Children's Hospital in Toronto, the Vancouver General Hospital, and the Neurological Institute in Montreal.

Canadians are proud of their system. It is a system that provides an excellent level of care across the country. Canadians would not trade it for any other.

Health care systems are very important to nations. They can provide benefits to a country or they can embody disadvantages that may have serious national

implications. I believe the Canadian health care system is important to Canada because it provides substantial benefits.

Canada has developed a health care system that has produced a relatively good level of health for our population. Canada ranks well internationally according to such health status indicators as life expectancy and infant mortality. Life expectancy at birth for women is 80.4 years; for men, 73.8 years. Our infant mortality rate is less than seven per one thousand live births (6.8).

I believe that the equality of access to health care that exists in Canada has been a critical factor in improving the health of our population. All Canadians have access to health care services regardless of sex, age, health or income level. We do not have one system for the rich and one for the poor. The poor and the sick do not go without health care because they cannot afford it.

I cannot say, however, that equal access to health care has produced equal access to health; we do have health inequalities among sectors of our population which persist for a variety of complex reasons. But I do believe that our health care system mitigates these discrepancies -- they would be much worse without universal access to health care.

The social benefits of our health care system are vital to Canadians. The fundamental principle of medicare is equity. All Canadians are treated the same, according to medical need, regardless of their ability to pay. This recognizes and fosters the compassionate nature of our people. I am convinced that this has spill-over effects -- effects that are visible in other social indicators, such as crime rates and homeless rates.

Our health care system has also fostered a sense of unity among Canadians. Canadian society is multi-cultural and diverse, and at the same time, strongly tied to North American culture. It is often difficult, therefore, for many Canadians to define themselves in a distinct way.

Health care is an exception. Our universal health care system is constitutive of our identity. Many of you may have met Canadians who have fiercely defended our system, and you may have wondered why we would be so emotional about it. Clearly it is part of **who we are** as a nation. It is the outward manifestation of fundamental, shared values -- the values, for example, of justice and care.

The economic advantages of our health care system are substantial. Our single-payer model, which covers about 72% of total health spending, has built-in

administrative efficiencies that have allowed us to keep total expenditures under control. Last year, we spent about 10% of Gross Domestic Product on health -- this level of total spending has remained stable for three years.

Spending control means that we have national resources available for other purposes -- for education, for housing, for research -- for other priorities which enhance the health and well-being of Canadians.

Economic advantages also accrue to Canadian businesses. Business is supportive of our health care system. Certain aspects of it provide them with competitive advantages in the global market.

First, our method of financing the health care system, primarily through a progressive tax system, ensures that the cost of providing health care services to the population is spread reasonably, and equitably, across society.

This means that Canadian businesses do not pay the costs of providing private health insurance for necessary hospital and medical services. Even after taking Canada's taxes into consideration, the cost of providing employee benefits in Canada is significantly less than in the United States.

Secondly, the national character of our system enhances labour force mobility. This is very important when responding to changing business requirements and opportunities.

Since health insurance coverage is based solely on residency, there is no "job-lock" in Canada. Workers need not fear losing health insurance coverage for themselves and their families because they change jobs or move to another province in search of employment. Canadians retain their coverage if they become unemployed.

Probably the most important way business in Canada benefits from our health care system is that access to quality health care helps to ensure a healthy and productive labour force.

Canada, in turn, benefits from a competitive business sector. Healthy business means economic growth. This means jobs. Jobs mean less unemployment, and less unemployment means a healthier population. A healthier population means fewer demands on the health care system and lower health care costs. We win all around.

The Canadian health care system is not, however, without its challenges.

Like the rest of the developed world, Canada has an aging population and demographic changes are putting pressure on health care systems. We are challenged to provide appropriate care to an expanding sector of the population that has traditionally required more health care services.

By "appropriate," I mean better care than we are providing now. It is not appropriate to institutionalize the elderly needlessly, to over-drug them, and to perform procedures that have no effect on chronic health conditions. We can do better.

An aging population will not bankrupt our health care system. It is not really aging that drives up health care costs -- it is the increasing amount of inappropriate services to treat the elderly that is the problem. This, we can, and are dealing with through the renewal of our health care system.

We are focusing more on community-based care as opposed to institutional care. We are redirecting resources toward health promotion and disease prevention. We are also making a concerted effort to ensure that the care we provide is appropriate -- that we do only what works.

One cost-driver which concerns us quite a bit is pharmaceuticals. Expenditures in this area of the health care system are increasing more rapidly than in any other. In 1993, total expenditures on drugs accounted for 15 per cent of the total health budget, up from under 10 percent just 10 years ago. Canada is looking closely at this area.

We need to know if this level of spending is appropriate. Is this the most efficient way to spend scarce health care resources? Is it too high? Alternatively, if drugs can be shown to be more cost-effective than alternative therapies, is it too low?

We already understand a lot about what is driving drug costs in Canada. Higher prices are one contributor, but the biggest increase is due to a combination of higher utilization and the adoption of new, usually more expensive, drug products without significant evidence about their cost-effectiveness. The issue of higher utilization leads to other important questions: are Canadians receiving the most appropriate drug therapy? And at a cost that is affordable? We need to gain a better understanding of the dynamics at work here.

Our health care system will continue to evolve. After all, we did not develop the current system all at once. It evolved over 40 years. We started first with public hospital and diagnostic insurance in the 1950s. Then we added public medical insurance in the 1960s.

Our "national" system was not completed until the last territory legislated medical care insurance. That was in 1972. Then, in 1984, we clarified the national principles at the federal level with the adoption of the *Canada Health Act*.

I am confident our health care system will meet the challenges it faces. As I mentioned earlier, health system renewal is already under way.

We will be assisted in this process by a **National Forum on Health** that is being created by the federal government. The Forum will be chaired by the Prime Minister and will be a vehicle through which Canadians can focus their priorities and plan the future of medicare. We will succeed. Our health care system is too important to Canadians and to our nation to do otherwise.

Nations are made stronger by sharing information and ideas. All nations must continue to improve and enhance their health care systems to deal with challenges. We in North America are no exception. I look forward to continued dialogue between Canadians and Americans in the years to come.

Thank you.



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Speaking Notes
for the
Minister of Health,
The Honourable Diane Marleau

National Conference on Immunization in the 90s:
"Challenges & Solutions"
Quebec, October 5, 1994



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Canada

Ladies and Gentlemen,

On September 29, in Washington, the Pan-American Health organization made a very special announcement: the total eradication of polio in the Americas. Together with 25 minister of health from all over the continent, I was honoured to be part of the ceremonies marking this wonderful event.

Canada has come a long way, in a short time, in meeting the challenge of immunizing its population against vaccine-preventable diseases. Only a generation ago, Canadians faced illness, disability and death as a result of diseases that are now largely under control.

In 1953, just a little over 40 years ago, there was an epidemic of polio in Canada. During that one year alone, 3,912 cases were recorded. While many of those young people affected by polio were having to learn how to walk again because of the disease -- and to learn how to live with the diseases' associated disabilities -- vaccines were perfected that would prevent it. In less than a decade the risk was almost completely gone.

Thanks to the actions of health professionals in every community and a committed public, Canada eliminated indigenous polio by 1977. By 1991, that success extended throughout the Americas, when the last case to be diagnosed was recorded in Peru. Today, we can state that polio has been eradicated from the Western hemisphere.

While only smallpox has been eradicated worldwide, polio is just one of many diseases that have been brought under control thanks to immunization programs. But this accomplishment should not lead to self-congratulation. If we were to ask people in the street about immunization, I suspect we would hear the belief that things are under control. That is not true enough to let us rest. There is a lot left to do.

There are still measles outbreaks every year -- over 300 cases reported to date this year. There were over 7,000 recorded cases of pertussis last year -- another disease that can be controlled through immunization.

So while we're doing a lot that's right, and should continue with our efforts, we should also be looking for new mechanisms, new ideas and new strategies to achieve our future goals.

The 1994 National Conference on Immunization represents a milestone on the road to fulfilling those goals for many reasons. This conference is not about disease. It's about practical applications of immunization programs. It's about enlisting broad support for those programs. It's about sharing what works. It's about working together. And, it's about finding ways to achieve our goals of disease eradication and prevention.

As Minister of Health, I am pleased that my department has been able to sponsor this event. It builds on the success of the 1992 National Conference on Immunization.

One major area of support for this conference is our **Brighter Futures** initiative. This initiative is a series of steps to achieve a better tomorrow for Canada's children. Creating the fundamentals of good health, such as immunization, helps us reach that goal.

An important guiding belief for **Brighter Futures** is one that our government also applies to most of its activities. We believe success is built on partnerships. In the case of health, we recognize that responsibility for delivery of services to most Canadians lies with the provinces. However, we also have our unique perspective and responsibility to all Canadians. Our involvement in this conference represents so many of our functions in Canada's health system: demonstrating leadership, co-ordinating, and encouraging the sharing of information.

One unique function is disease surveillance. Recent events in India and the repercussions around the world demonstrate the potential for diseases to spread via modern transportation. For this reason, we have increased our surveillance of plague both inside and outside of Canada. In addition, we have taken precautionary measures to prevent this disease from entering Canada, and continue to provide advice to Canadian travellers to India. We will do our best to protect Canadians from this preventable, curable disease.

Disease surveillance tracks vaccine-preventable diseases, HIV/AIDS, and other health conditions and behaviours that can be used to monitor our health status.

A sense of shared commitment extends throughout this conference. The federal government is hardly alone in its commitment on this issue. To that end, I welcome the interest and support we have received from provinces and the private sector in funding this conference.

The theme of this conference is "*Challenges & Solutions.*" That's what you will be doing over the next few days -- discussing the challenges you face daily, and seeking solutions to the questions of vaccine supply and delivery, program assessment, education, and global immunization, among others.

These are clearly matters that occupy the men and women on the front lines of public health campaigns.

This conference has brought together health care professionals and other individuals who share an interest in immunization. It will provide a forum for sharing experiences, and will result in increased knowledge that you will put to good use when you return to your practices.

One aspect of this conference deserves particular mention. That is workshops organized on issues affecting Aboriginal communities. The participation of Aboriginal peoples in conferences such as this one is crucial, and the involvement and leadership demonstrated by Canada's aboriginal peoples in addressing their immunization needs through this event should serve as a model for other health conferences.

Canada's Aboriginal people have their health traditions and practices. We must address Aboriginal health issues in an atmosphere of respect for their traditions and full involvement for First Nations governments and organizations.

The perspectives of Aboriginal participants about the real immunization issues facing their communities should provide us with one more vehicle that we can use to reach our national goals.

One lesson which Aboriginal people have already shared with us is the value of the family unit and the importance of support throughout the entire community. Many of the challenges of filling the gaps in immunization coverage relate to family beliefs or dynamics. It is valuable to keep this in mind at any time, but it is perhaps even more pertinent during 1994 -- the **International Year of the Family**.

As Minister responsible for the **International Year of the Family**, I know that in times of change like these, families need support. This is where governments, working together with volunteer and private sector partners, and health care professionals can make a difference.

A central goal of Health Canada is to ensure that Canadian families are healthy families. One contribution to their health is our responsibility for vaccine safety.

Clearly, many parents are concerned about the unintended effects of vaccines on their children. Some would rather run the risk of disease than the smaller risk of adverse effects. Our role is both to educate and to ensure that risks are reduced to the lowest level possible. And we depend on you to assist us in that work.

The changing dynamics of family life point out problems that we must address. One is that families move much more than they used to. With that and the advent of walk-in clinics and other forms of medical service, people are less and less likely to have one comprehensive set of medical records. This means children are less likely to have consistent health and immunization records.

The impact is a growth in the number of people who may lack appropriate protection for no reason other than no one can tell whether they have or have not been immunized. Privacy concerns notwithstanding, there must be a way to create a unified database allowing people's immunization records to be maintained and accessed, regardless of where they live.

I intend to explore the viability of a national immunization record database with my provincial and territorial counterparts. I am also committed to placing disease prevention goals on the intergovernmental health agenda.

We have proven that disease can be eradicated here in Canada through effective and comprehensive immunization programs. And, through our work with the Canadian International Development Agency, the Pan-American Health Organization and the World Health Organization, we are working to extend that protection to people around the world.

Immunization has become one of those elements of modern medicine that is often taken for granted. But investments in immunization and disease prevention programs are investments in health, investments in the family, investments in our future.

Canada and Canadians have made tremendous progress in disease prevention through immunization. But we cannot afford to become complacent.

Progress will come through continued commitment at all levels of government. It will result from the dedicated efforts of health care practitioners. And, it will demand innovative thinking on the part of all of us. This conference will feed that innovation.

I am committed to doing my part, and I look forward to your help and support as we work together towards a truly healthy society.

Thank you.



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Speaking Notes
for the
Minister of Health Canada
The Honourable Diane Marleau

Xth International Symposium on Atherosclerosis
Montreal, October 9, 1994



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Canada

Members of the International Organizing Committee, distinguished delegates ...

On behalf of the Government of Canada, it is my pleasure to welcome you to this International Symposium.

I am delighted that you have chosen Montreal as the site of your deliberations.

You have travelled from all corners of the world to share scientific knowledge in the prevention of cardiovascular disease, a major cause of death, disability and health care costs in both developed and developing countries.

The many countries represented here today attest to the global nature of the agenda that your Symposium will address.

The fight against cardiovascular disease is a major public health success in Canada, for which both health promotion and the health care system can take credit.

Just a few years ago, cardiovascular disease was a matter for a physician's office. Today, heart health is an issue in the public domain.

We know from our provincial heart health surveys that 2 in 3 adult Canadians have one or more of the risk factors for heart disease and about one in two have elevated blood cholesterol.

It is clear that issues of prevention need to be addressed through a public health approach.

In our country, the Federal-Provincial Heart Health Initiative is our response to this challenge.

The Initiative is a joint effort involving Health Canada, the provincial departments of health, the Heart and Stroke Foundation of Canada and numerous other professional organizations.

To succeed in our prevention endeavours, we need to bridge that gap between the scientific knowledge of prevention and the lifestyle determinants of the risk factors.

The **Victoria Declaration on Heart Health** makes the point that now we have the scientific knowledge to eliminate this man-made epidemic.

Many of you in the audience have contributed to this landmark document and we now face the challenge of implementation.

Your Symposium is a step forward on the road that can improve the quality of life for hundreds of millions of people around the world.

I wish you every success in your deliberations... Thank you.



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Speaking Notes
for the
Minister of Health,
The Honourable Diane Marleau

Announcing the Establishment of
*The Steering Committee on Breast Cancer
Care and Treatment Guidelines*

Canadian Breast Cancer Foundation
1994 Awareness Day Luncheon
Toronto, October 12, 1994



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Your Honour, Your Worship, head table guests, ladies and gentlemen.

For too long, breast cancer has been one of the most silent killers in Canadian life. A disease that strikes one in every nine Canadian women during their lifetimes, and that will kill more than 5,000 of us this year alone, has had little profile. Research has been underfunded. Care has been inconsistent. The needs of women with breast cancer are often not fully met.

As Minister of Health and as the Member of Parliament for Sudbury, I have been able to note that the situation is improving dramatically. It has changed because women like many at this luncheon today have made it change.

Women, such as the ones who created the Canadian Breast Cancer Foundation, and those who are creating the Canadian Breast Cancer Network, are determined to end the silence that prevailed around this issue for many years. They are expressing their feelings, sharing their experiences and organizing to make their voices heard. They are taking the pain that thousands of women feel every year and transforming it into action.

And action it has become. As one who has been active in cancer issues in my own community, I was pleased to be involved in the **National Forum on Breast Cancer**, almost a year ago in Montreal. Funded under the **Federal Breast Cancer Initiative**, it was a milestone.

It marked the first time that Canadian professionals, scientists, volunteers, survivors and their families had met to discuss priorities and directions in the research, treatment, prevention and screening of breast cancer. They found common cause. They found shared commitment and a willingness to listen. And that commitment has continued at many levels since the Forum.

Today I am pleased to announce that a distinguished group of Canadians will be meeting in Ottawa on November 2, 1994 to form the **Steering Committee for Care and Treatment Guidelines**.

A major concern in the treatment and care of breast cancer is the lack of a comprehensive set of clinical practice guidelines -- evidence-based statements that can be used as decision-making tools by women and health care practitioners.

The **Steering Committee for Care and Treatment Guidelines** will set priorities for specific guidelines and oversee their development and implementation. Women with breast cancer are represented on this Committee as are health care professionals, educational and licensing bodies, and government and non-government cancer agencies. My Department has committed \$300,000 over five years to this initiative.

I look forward to hearing that the work of this Committee has made a difference for the lives of women when they seek treatment in their communities.

I am also pleased to highlight that as of this date, the **Canadian Breast Cancer Research Initiative** -- a partnership between Health Canada, the Medical Research Council, the National Cancer Institute of Canada and the Canadian Cancer Society, has funded 24 projects totalling \$6.8 million over three years.

These projects are investigating dietary and other risk factors for breast cancer as well as researching issues relevant to prevention, treatment, care and support. Overall, this Initiative has increased the resources available for breast cancer research in Canada by 150 per cent over resources available in 1993-94.

These examples provide firsthand information that the Forum made its mark on 1994's efforts. Perhaps above all, the Forum gave us something special -- a "spirit" that is clearly here today.

Every one of us in this room probably knows someone who has, or has had, breast cancer. This disease still claims lives every single day. The difference between now and ten years ago is that the attention of society is turning to this issue.

It is through events like this, that our fight against breast cancer will continue. Through the broad base of support this luncheon demonstrates, our efforts will grow stronger. I would like to congratulate Carole Grafstein and the members of the organizing committee for their work in reminding us all that "Together, we will succeed".

Thank you.



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Speech / Discours

Speaking Notes
for the
Minister of Health
The Honourable Diane Marleau



Sudbury and District Council on Tobacco or Health
"Helping Students Kick Butt"
A Tobacco Forum for Youth
Sudbury, October 14, 1994

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Thank you. It's good to be home among friends this afternoon. I trust that the conference was stimulating and productive.

The theme of your conference and seeing so many fresh young faces in the audience brings back memories of my own childhood in Northern Ontario.

As I remember it, growing up was *hard*. But if it was hard in the 50s, it's probably even harder today. Pressured to conform; yearning to be different; struggling to carve out an identity that's yours alone in a world that seems to belong more to grown ups than to teenagers. I don't envy you, well..., maybe just a little.

We didn't know back then about the risks associated with smoking -- but we do today. Why is it, then, despite years of explicit health warnings, young people continue to take up smoking in such large numbers?

Today, fully 27% of 15 to 19-year olds smoke. And if anything is *more* alarming, it's that over half of them are female -- 29 % of young women in this age group smoke, compared to 26% of young men.

Unfortunately, regular use soon results in addiction to nicotine. And, as many young smokers find, kicking the habit isn't very easy. It is often the temptation to socialize with family members or friends who smoke and the inability to find other ways to relax that draw many back.

The good news, however, is that the chances for long-term success at quitting increase with the number of times you try. So it's heartening to see groups like yours exploring ways to help teens quit. For its part, Health Canada has produced two cessation resources you may not know of:

♦ ***Quit 4 Life*** -- produced in partnership with the Canadian Lung Association, is a self-help program for teen smokers aged 15 to 19 who are already motivated to quit smoking. You may have heard about it on Much Music. (To obtain a package call 1-800-363-3537.)

♦ ***Diary of a Teenage Smoker*** -- is a video directed at girls aged 12 to 15, and well suited for classroom use. It looks at why young women smoke, examining the influences of stress, advertising, self-esteem and peer pressure, and it offers teenage girls some tips to help them become smoke-free. Copies of the video will be going to Canadian schools this year, as part of the government's **Tobacco Demand Reduction Strategy**.

Health Canada is also planning to develop a national high school action plan on tobacco that will look at gaps in high school anti-tobacco programs. It will also examine the roles played by educators, parents and other adult influencers.

But the real push will have to be in prevention work. Our survey of smokers in Canada last spring indicated that nearly all first-time use of tobacco occurs before high school graduation. We know that the earlier a person takes up smoking, the more likely he or she will become an adult smoker, and a heavily addicted one.

In 20 years of anti-tobacco programming, these individuals are among the groups that we have found the hardest to influence. So the case for prevention is powerful. If we can reduce the number of children and teens who take up smoking, we can stand a better chance of keeping them smoke-free for life.

In the 1970s, more women began smoking and the results are already apparent. We see it in the growing numbers of female deaths from smoking-related illness; in the rising incidence of heart disease in women; in the fact that female deaths from lung cancer now outnumber deaths from breast cancer.

And, closer to home, according to a community profile prepared by the Proposal 2000 group, I understand that women in Sudbury have the highest lung cancer death rate in Canada.

We are planning to launch a multi-media advertising campaign in late fall to deliver a number of messages to Canadians about the issues related to tobacco use.

We're also going to put fresh resources into research to learn more about the nature and scope of adolescent smoking so we can develop more effective anti-tobacco programs. What makes young people, especially young women, decide to take up smoking is one of the questions we will seek to unravel.

With the provinces, Health Canada is studying cigarette packaging -- including generic packaging. Teens, as you know only too well, are an important market for the tobacco industry. We believe that cigarette packaging is one of the key ways tobacco companies attract the youth market now that tobacco advertising is illegal.

The government's efforts to make good policy and develop more effective programs would be futile were it not for the enthusiasm of organizations like yours. You make things happen!

To help mobilize communities, the federal government will be funding local anti-tobacco initiatives by non-profit organizations and community groups.

Over the years, Health Canada and the provincial and territorial health ministries have developed valuable partnerships with health care organizations, voluntary groups, and the private sector. These partnerships have been a great way to get effective results, particularly through the **Community Action Initiatives Program** of the **Tobacco Demand Reduction Strategy**.

I was delighted to learn of the stewardship role taken by tobacco retailers in Sudbury through "*This Business Loves Kids*". Their commitment to preventing tobacco sales to minors in this community is exemplary. I also commend the school boards for their "smoke-free schools" policy and for their holistic approach to health education, not to mention the vitality of your own heart health program.

In a city where the incidence of smoking exceeds the national average, none of your efforts will be lost. I wish you the very best of luck.

Thank you.



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Speaking Notes
for the
Minister of Health
The Honourable Diane Marleau



National Conference on Nursing Administration
"Leading In A Time Of Change"
Ottawa, October 17, 1994

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Good morning everyone

I am pleased to be here this morning and I thank you for your invitation to participate in this National Conference on Nursing Administration. I welcome the chance to share ideas about the ways we can work together to renew Canada's health system.

Congratulations to all those who had the foresight to organize this timely event.

"Leading in a time of change." I believe that this is the key for all health professionals in the 90s. I applaud you for your foresight and vision in adopting such a progressive theme for your symposium.

Change is inevitable. History has repeatedly demonstrated that. And nowhere is the pace of change -- or the pressures it imposes -- greater than in the health sector.

Like you, I believe we must lead -- rather than be lead -- so that we can shape the future according to our values and our needs as Canadians. Our responsibility is to make the most of the opportunities that change represents.

As you know, the Prime Minister will be chairing the first meeting of the **National Forum on Health** this Thursday, in Ottawa.

The Forum is a formal acknowledgement of the need for change and the desire to capitalize on its positive potential. We cannot stop the future. But we can surely help shape it.

Governments are often accused of dealing only in the short term. Well, ladies and gentlemen, this Forum is meant to look at the medium to long term.

The 21st Century is only five years away. Change is happening at break-neck speed. We must look first to keeping Canadians healthy -- free from chronic diseases or illness, as long as possible. For only in good health, will Canadians be productive and prosperous.

When illness does strike, we must look to providing the most advanced technologies, the most advanced and efficient drug therapies, and frankly, the very best care possible. We must ensure that the dollars we spend go towards the very best in health care.

Canadians deserve no less. This is a task for the Forum.

Twenty years ago, Marc Lalonde introduced the concept of responsibility for health care shared between the federal and provincial governments.

Later, Monique Bégin gave our national health insurance plan its five fundamental principles: it is comprehensive, universal, accessible, portable and publicly administered.

The Federal Government has traditionally played an important role in the health sector. Canadians believe the federal government should, and will, provide leadership for the on-going development and safeguarding of a national health system.

The Forum will build on the principles of the *Canada Health Act* and the values that underlie it. The values of care, justice and yes, of competitiveness.

Whether they live in Cornerbrook, Newfoundland or Victoria, British Columbia, Canadians want to be assured they will receive the same level of treatment and have equal access to quality health care.

The **National Forum on Health** is the vehicle that will assure we can continue to meet those expectations and satisfy the evolving health needs of Canadians.

Selecting the Forum members was a difficult exercise. There was interest from all across the country. Our aim was to achieve a balance between volunteers, professionals and consumers knowledgeable about the health system.

They represent every region in the country. They each share a genuine willingness to foster a national dialogue on health renewal and to develop broad directions for Canada's health system that will carry us into the 21st century.

They will reach out to Canadians from all walks of life to involve Canadians in a dialogue on the issues and in the development of a future vision.

The **National Forum on Health** is an advisory body to the federal government. It fulfils a Red Book commitment. The actual work of reforming the health system is not the sole responsibility of the federal government. Provincial and territorial governments play a major role in this process.

The Conference of Health Ministers continues to be the key

intergovernmental decision-making body for health system renewal.

In developing the Forum, provinces and territories have been consulted. In fact, many of the Forum appointees were recommended by ministers of health.

I am pleased that the nursing profession is ably represented in the Forum.

Among those recently appointed by the Prime Minister are Madeleine Dion Stout, past president of the Aboriginal Nurses Association of Canada and Judith Ann Ritchie, past president of the Canadian Nurses Association. These individuals are well positioned to sensitize Canadians to your profession's concerns and to provide leadership as we undertake this task.

I believe the composition of the **National Forum on Health** speaks volumes about our approach to health renewal. The Forum members include volunteers, professionals and consumers and were selected for their knowledge of, or experience in, the health field at the "grassroots" level. Therein, I believe, lies the Forum's strength.

We want to mobilize all points of view, particularly those of care providers and consumers. Because, ultimately, it is up to each and every citizen of this country to determine the direction we want to move in and how we propose to get there.

And this is where you come in. As the largest group of health workers in this country, nurses and nurse managers know intimately the many problems facing the health system. You are witness to the daily impacts of service and fiscal pressures. It is most often your members who respond to these demands, who seem to be forever asked to do more with less.

You have consistently shown you are up to the challenge. You are at the forefront of the health system renewal.

You recognize that health renewal is necessary not only as a cost containment measure, but as an opportunity to do things right.

It's my view, and I know that you endorse this view, that the right health service should be provided by the most appropriate caregiver, in the right setting, in the most cost-efficient manner, at the right time -- every time. This philosophy lies at the heart of our health renewal efforts.

I welcome the Integrated Human Resources Development Framework being co-developed by the Canadian Nurses Association and three other professional groups. A flexible and dynamic workforce must be developed that is capable of adapting to ever changing needs.

Your Framework fits in well with work underway to respond to the shift from an institutional to a continuum-of-care model. As partners in the Federal/Provincial/Territorial Working Group on Integrated Health Human Resource Planning, we, too, are examining the new types of health workers who will be needed; the multi-disciplinary training they will require; and the different delivery structures that must be developed to accommodate these new trends.

Through these efforts, we will be in a better position to address the implications of health reform for nursing. We are working closely with your organizations, and our provincial and territorial counterparts to enhance your already invaluable role in the health system.

Nurses and nurse managers make a dramatic difference to the quality and effectiveness of health care delivery in this country. Your compassion for Canadians and commitment to provide optimal care add immeasurably to the health and well-being of our nation.

As front-line workers, coming into daily contact with Canadians, you, both literally and figuratively, have the pulse of the nation. As such, you have a vital contribution to make to the **National Forum on Health**.

This conference is proof of your willingness and desire to assume a leadership role. The Forum will provide an opportunity for each and every one of you to do just that.

I look forward to continuing our collaboration with you, as individuals and associations, as we work together to find the right fit for nurses and nurse managers within a renewed health system.

You know first-hand how proud Canadians are of their health system. It's a system that provides an excellent level of care across the country. We have developed a health care system that has produced a relatively good level of health for our population.

It's a system that treats all Canadians the same, according to medical need, regardless of their ability to pay. It's a system that recognizes and fosters the compassionate nature of our people. Our system has also fostered a sense of unity among us. In fact, it is constitutive of our identity. Clearly, it is part of who we are as a nation. Canadians would not trade it for any other.

I have no doubt you will identify and exploit numerous opportunities as you carve out new niches for your profession in the fast evolving health field. Working smarter, mixing compassion with the best of modern medicine, you will successfully adapt to the rapidly-changing global economy.

The nursing profession has the right attitude: there is no way to avoid change. The best way is to deal with the change and to shape the future according to our values and our needs.

As the primary caregivers in this country, as the very nerve centre of our health system, who better than you to take on this challenge? We as Canadians will all be winners in Canada's renewed health system!

I am grateful for your support of the Forum. We will succeed. Our health system is too important to Canadians and to the nation to do otherwise.

Thank you.



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Speech / Discours

Speaking Notes
for
the Minister of Health
The Honourable Diane Marleau



Announcement of a Contract with
The Winnipeg Aboriginal Head Start Steering Committee
and
three programs under the
Community Action Program for Children
Winnipeg, October 28th, 1994

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Ladies and Gentlemen, thank you for joining us here today.

In the one year since this Government came into office, my colleagues and I have worked to fulfil the commitments we made to Canadians in the Red Book.

Two of our most important pledges were to invest in the health and well-being of Canada's children and to work with Aboriginal peoples to develop an Aboriginal Head Start program.

Today, I want to let you know that we are meeting these commitments. I also want to announce four new partnerships with the Winnipeg community.

Canada's Aboriginal population is much younger than our population overall: 38 percent are under the age of 15, compared to 21 percent of the total Canadian population. Some 51 percent of all Aboriginal children live in poverty, compared to 18 percent of children in our total population. These children face health, social and other disadvantages that are unacceptable.

The Red Book outlined this government's commitment to addressing these disparities.

On September 26, I announced a strategy called *Building Healthy Communities*. It has a budget of \$243 million. That's four times the current resources devoted to aboriginal health in three critical areas -- solvent abuse, mental health and home care nursing, for First Nations and Inuit peoples.

In addition, we will enhance and expand the transfer of resources to First Nations and Inuit communities, at a pace to be determined in consultations with them.

For Aboriginals living off-reserve, the Red Book proposed an approach based upon an innovative, community-centred program developed more than thirty years ago in the United States. The Head Start program has led to important improvements in children's health, in education, and in their skills in dealing with the challenges of growing up. Since the program's approaches are community-defined, it has fostered pride in individuals and in communities.

The federal government has consulted with provincial and territorial governments, with Aboriginal communities, and with parents and individuals across Canada.

We have sought advice on how to develop a "made-in-Canada" early intervention program that will address the unique needs of Aboriginal children living off-reserve in urban centres and large Northern communities. From the outset, our intention has been that the program will be designed and controlled by Aboriginal people.

For the past four months, officials in my Department have consulted closely with Aboriginals in every province and territory. We have met with more than 200 community organizations. We have listened carefully to their many valuable insights and recommendations.

Today, I am pleased to announce an important landmark -- an agreement with the Winnipeg Aboriginal Head Start Steering Committee to develop an integrated Head Start program in this city.

The \$48,000 contract will permit the Head Start committee to continue its planning, research and program development. The Winnipeg Aboriginal Head Start Steering Committee program will serve as a model for other communities, enabling them to accelerate their Head Start programs.

This is fitting since our consultations began here. We were impressed from the outset by the strong sense of community cooperation and the collective determination to develop a program that would meet the needs of Aboriginal children and parents in the Winnipeg area.

Today's agreement marks the end of this round of consultations. We can now begin to develop a Head Start program model that will address community-defined needs and that will reflect Aboriginal values, culture and languages.

I am also pleased to be able to announce close to \$1.7 million in funding for three programs under the federal government's Community Action Program for Children (CAPC). The projects I am announcing today have the support of the province of Manitoba and of Winnipeg community organizations.

The Abinotci Mino-Ayawin program is sponsored by the Aboriginal Health and Wellness Centre in partnership with the Children's Home of Winnipeg and the City of Winnipeg Health Department. It is designed to provide in-home services and neighbourhood programs focusing on parent education and support, healthy pregnancies and healthy child development in ways that reflect the cultures of Aboriginal families.

The Central Park West End Outreach Project is sponsored by the Citizenship Council of Manitoba, the Villa Rosa shelter for pregnant adolescents and the Knox Day Nursery. It will promote parenting skills. It will use community kitchens and recreational programs to engage parents and children in activities that will help them identify and use existing community services.

The third project involves the Mount Carmel Clinic, Winnipeg Child and Family Services, Your Parents Community Centre and the Children's Home of Winnipeg. Children who are developmentally delayed as a result of fetal alcohol syndrome, as well as their parents, will benefit from direct support programs that will provide improved opportunities for these children to reach their full potential.

Like the **Aboriginal Head Start Program**, these three projects reflect this government's commitment to invest in community-based strategies to promote the health and well-being of children.

We are placing our investment at the local level because of the significant expertise, knowledge and dedication to be found there.

We are developing solutions and working with those groups and individuals who are most directly involved. They, like you, know only too well the nature and magnitude of the problems that must be solved if we are to ensure a healthy and safe future for Canada's children.

It is a great pleasure to be here, to recognize the work of some of Winnipeg's community organizations and to be able to support their efforts.

Thank you.



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des territoires

Speech / Discours

Speaking Notes
for the
Minister of Health
the Honourable Diane Marleau



Association québécoise de gérontologie
15th Annual General Meeting
Quebec, November 4, 1994

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Canada

Madam President, distinguished members of l'*Association québécoise de gérontologie*, I am extremely pleased to be with you on this final day of your 15th annual congress.

Through conferences, research and publications, your association has contributed greatly to our understanding of the questions and issues related to all aspects of gerontology.

As the federal Minister responsible for the health and well-being of seniors, I share many common concerns with your association. On the threshold of the 21st century, the Canadian population is rapidly changing. We have to take into account the needs of seniors and to forecast those of our aging population.

I would like to take this opportunity to talk to you about two issues that are priorities for our government, namely our willingness to target our initiatives in the right direction and to adapt to the new social and economic realities.

We attach great importance to the promotion of seniors' independence, particularly for those who are most vulnerable. Seniors wish to stay independent as long as possible. We support that wish. To ensure the preservation of this independence, we also attach great importance to prevention in all of its forms.

Moreover, we favour the adoption of a health care system that relies more heavily on community-based resources. To help those who cannot manage alone, those whose needs are the most pressing, we support projects aimed at providing assistance to caregivers and those who provide services to seniors.

Our government has taken concrete measures that bear witness to its commitment to these priorities. And we intend to continue. This morning I am pleased to announce the funding of four applied research projects which promote seniors' independence and support community resources.

The first is the project of François Béland of l'Institut universitaire de gérontologie sociale du Québec. "**Vieillir dans la communauté: santé et autonomie**", is aimed at assisting community facilities, other than hospitals, that provide care over long periods of time -- one can think of the CLSCs -- to tailor their services to the community, and to integrate them with the other resources already available.

The second project, being carried out by Dr Robyn Tamblyn's team in the McGill University Department of Epidemiology, promotes the best possible use of medication by seniors. The frequency and cost of illness related to improper medication use would therefore be reduced.

Although seniors account for 12% of the Canadian population, they are the consumers of 28% of all prescription medication. There is no doubt that medication improves the quality of life and the life expectancy of many seniors. But we must strive to avoid overconsumption and improper use in all its forms.

Here I would like to add that earlier this year, my Department funded a project enabling seniors in a Northern Ontario nursing home to participate actively in the case management of their own treatment where medication is required.

A third project, "**Évaluation de la prise en charge des personnes âgées fragilisées**" is preventive in nature. It affects our most vulnerable seniors: those for whom the slightest fall, the most trivial accident or incident, almost always means the loss of independence at home or of mobility in an institution. Under the direction of Dr André-Pierre Contandriopoulos, a team of researchers from the University of Montreal will study the means required and the improvements necessary to avoid accidents in these seniors' physical and social environments.

The final project is a collaboration between Laval and Dalhousie universities and involves mutual aid and self-help groups for seniors and their family caregivers in three regions in Canada, namely Nova Scotia, Quebec and Ontario. Dr Francine Lavoie, Professor at the School of Psychology of Laval University, is the principal co-investigator of this project.

I would like to congratulate all those involved in the development of these projects. My department will be allocating 2.4 million dollars for their fulfilment. This initiative was undertaken through the **Seniors Independence Research Program**, in conjunction with the **National Health Research and Development Program**. I would like to add that today's announcement comprises nine other projects in other Canadian provinces.

I will now move on to the second of our major concerns: predicting future needs, adapting our health care system to our evolving society, and, what interests us most, preparing well to meet the needs of an aging population?

Fortunately, we have the resources to assist us in this exercise.

First, we can count on organizations like yours to help direct our interventions on the right path. For example, let us consider this conference that concludes today. The topics you will have addressed -- caregiving, elder abuse, seniors at risk -- will cast new light on these issues and we will take that into account.

On the other hand, our government commits itself to tackle the challenge presented by the reduction of our financial resources. We no longer have the choice: we have to "do more with less". We strive to achieve maximum value for every tax dollar dedicated to the health budget. We must pool our resources with other governments, organizations, community groups and individuals. We must avoid duplication at all costs. This is the only way to ensure efficiency not only of our interventions, but also of the very existence of our programs.

The **National Forum on Health** will provide us with other vital elements for our response. The Forum was created to adapt our health system to the new social and economic realities. It will create a vision for health care in the 21st century.

One part of that vision will relate to the health care of seniors. The Forum will provide an opportunity to address our current practices and to determine policies and programs for the future.

The inaugural meeting of the Forum took place on October 20. Chaired by the Prime Minister, it is made up of 22 Canadians, health professionals, volunteers or health care consumers from across Canada. They have a first-hand understanding of health care issues, and some of them are particularly sensitive to seniors' issues: one member, I might add, is 72 years old.

One of the mandates of the Forum is to engage in a frank and open dialogue with Canadians, listening to what they have to say, and making sure that others hear it as well. I invite you to contribute to the Forum. Your experience and knowledge are vital to the success of this undertaking; seniors' voices must be among those heard. Their wealth of knowledge and experience is impressive. Who better than a senior to understand the needs of another senior?

In closing, let me point out that those whom we wish to help can also help us. Today's seniors have lived through hard times and have often had to tighten their belts -- they are truly experts in making a little go a long way.

As Jacques Grand'Maison and Solange Lefebvre so aptly stated in *La part des aînés*, "We can learn much from seniors at this historical turning point, this abrupt change from easy prosperity to unexpected austerity, which calls for changes in values and new coping skills."

Let us count upon our seniors. Let us draw inspiration from their experience and wisdom.

Thank you.



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Speech / Discours

Speaking Notes
for the
Minister of Health
The Honourable Diane Marleau

Première Screening of "*Goldtooth*"
First Canadian Conference on International Health
Ottawa, November 13, 1994

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Ladies and Gentlemen, I am honoured to be here to mark the première screening of "*Goldtooth*".

- ◆ *Goldtooth* is an important film for children -- and one in which Canadians can take great pride.
- ◆ As Minister responsible for the health and well-being of Canadian children, I'm pleased with Health Canada's role in funding *Goldtooth* through our Partners for Children Fund.
- ◆ The film is the product of a two-year partnership between Health Canada and Street Kids International. It has brought together a number of key players -- child health researchers, an Academy Award winning director and world class animators -- to create an important educational tool on substance abuse for street workers.
- ◆ *Goldtooth* cuts across borders, cultures and time zones to meet children where they live ... and to speak to them in terms they understand.
- ◆ *Goldtooth*'s cross-cultural themes are universal and compelling, they deal with self-respect, friendship and decision-making. They are conveyed in images and words that kids can relate to.
- ◆ This film makes kids think long and hard about why they use drugs and the dangers involved. Field testing with young people in ten countries has shown that the film is as effective with street youth in Mexico City and Bombay as it is with kids in Toronto or with native youth in Northern Canada.
- ◆ *Goldtooth* promotes the basic rights of children -- those outlined in the **UN Convention on the Rights of the Child**. It respects children and speaks to them honestly about the problems they face.
- ◆ The film is based on the premise that all children -- including street kids -- have legitimate needs and concerns. Most importantly, it conveys that every child should be treated with dignity.
- ◆ Like the highly acclaimed Street Kids International "**Karate Kids**" cartoon on AIDS, *Goldtooth* will be translated into numerous languages and distributed to as many as 100 countries worldwide.

- ◆ In Canada, this première screening of *Goldtooth* comes at a fitting time. In just one week -- on Sunday, November 20th -- Canadians will be celebrating our second annual **National Child Day**.
- ◆ This date was chosen with children in mind. November 20 is the anniversary of two historic events for children: the adoption of the UN Declaration of the Rights of the Child on November 20, 1959; and the adoption of the UN *Convention on the Rights of the Child* on November 20, 1989.
- ◆ **National Child Day** is a day to celebrate children ... just for being themselves. It is a day for all Canadians to remember that children all around the world need love and respect to grow to their full potential. It's a day to remember that we must listen to children and marvel at their uniqueness and all they have to offer.
- ◆ **National Child Day** is also an opportunity to reflect on the ways of working together to create a better tomorrow for all children. A film like *Goldtooth* is an excellent example of this.

I thank the Canadian Society for International Health for organizing this event. I wish all of you a very productive and rewarding conference. Thank you.



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Speaking Notes
for
The Honourable Diane Marleau
Minister of Health

Canadian Bioethics Society -- 6th Annual Conference
Ottawa, November 26, 1994



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Speaking Notes
for the
Minister of Health
The Honourable Diane Marleau

Canadian Medical Education:
Responding to HIV/AIDS in Canada
Ottawa, November 14, 1994

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It is a pleasure to be here with you this morning to launch the Canadian Medical Education conference on "Responding to HIV/AIDS in Canada."

I want to thank the President of the Association of Canadian Medical Colleges, Dr. David Hawkins, for inviting me to open your discussions.

In the past year, I have consulted with physicians who treat patients with HIV/AIDS, people living with AIDS, and their support groups. I am concerned with this issue, both as a person and as a politician.

Clearly, the challenges are great. We are only beginning to understand and address the complex dimensions of this disease, yet the casualty figures continue to climb. There have been an estimated 15,000 cases of AIDS in Canada to date. There are an additional 27,000 Canadians who are living with HIV and we expect 15,000 of them to develop AIDS by the year 2000.

As you know, HIV disease and AIDS have profound impacts on public health and costs to our economy, and have raised human rights issues.

Therefore, it is critical that we collectively examine our approach to HIV/AIDS medical education, to learn from past experience and prepare for the future.

Phase II of the **National AIDS Strategy** supports professional organizations in developing educational resources and enhancing the capacity of health care professionals to meet the HIV/AIDS challenge.

I congratulate the Association of Canadian Medical Colleges for moving this agenda forward and for encouraging such a collaborative environment.

I would like to point to the partnership you have established between providers and consumers of care. This is integral to achieving the understanding necessary to produce practical tools for today's medical students -- tomorrow's health practitioners -- practical tools that respond to issues of concern to patients.

But having the tools is not enough. Putting knowledge into practice requires that physicians become sensitized to HIV/AIDS early in their training. Medical curricula should expose students to people living with AIDS. This would give our future physicians a sense of the specific needs AIDS entails, as well as involving them in the decision making regarding patient treatment and care.

They must learn to respond not just to the medical, but the psychosocial issues they will confront in providing care. These skills need to be reinforced and sustained throughout their training.

Over the lifespan of this chronic condition, physicians and patients -- working and learning together -- must make difficult but appropriate decisions for persons living with the disease. The foundation on which that relationship is built is critical to quality patient care.

I applaud your goal to create uniform learning objectives for undergraduate and postgraduate medical curricula across the country. I also believe it is essential to equip Canadian physicians with the necessary knowledge and skills to provide comprehensive care to people living with HIV and AIDS.

The creation of a national network to monitor and provide support for the implementation of HIV/AIDS curricula will ensure we remain responsive to the evolving nature of HIV disease and up-to-date on the most appropriate care and treatment approaches.

I commend your Association for taking an insightful and proactive approach to this issue and assure you of my support for your goals.

I am anxious to hear your views about creative approaches and answers to the rapidly-changing challenges confronting Canadians with HIV and AIDS.

Solutions may not be easy but neither are they impossible. I encourage you to maintain the momentum. By working collaboratively, we will continue to achieve great progress. Thank you.



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Speech / Discours

Speaking Notes
for the
Honourable Diane Marleau
Minister of Health

First Nations Health Conference
"Pathways to Holistic Health"
Calgary, November 28, 1994



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National Chief Mercredi. Elders, Chiefs, ladies and gentlemen, good morning and thank you for inviting me to the First Nations health conference.

Meetings such as this one are critical to the process of building partnerships between governments, First Nations and health care workers -- partnerships which I believe are the key to achieving further improvements in First Nations health.

I am pleased to be sharing the podium today with National Chief Mercredi. I know Chief Mercredi has focused much of his attention over the past year on the wellness of First Nations communities.

I commend him for that. I agree that community health and well-being is an important starting point for achieving economic, social and political gains.

I also believe it is important for us to work in partnership with First Nations communities at the local and regional levels.

The AFN provides a national focal point for consultations on health issues -- discussions like the ones that will take place here in Calgary over the next few days.

All such consultations, whether they are in the form of a national conference or a community meeting, will contribute to our shared objective: to help improve physical and mental health conditions in First Nations communities across Canada. It is most important that First Nations and Inuit communities be involved in consultations.

I can assure you that as Minister of Health, I know improvements are needed. Although some important progress has been made in First Nations and Inuit health status over the past three decades, much more needs to be done.

Our health care system is one of Canada's proudest achievements: it helps define us as a nation. But the fact that one group in society -- Aboriginal people -- has historically suffered poorer health than other Canadians, is a blemish on that achievement.

In the Red Book, the Liberal government makes a commitment to work toward a greater equality of social conditions among Canadians. The Red Book speaks of a future where Aboriginal people enjoy a standard of living and quality of life and opportunity equal to those of other Canadians.

Health is obviously a key factor in this equation. Since we formed the government a little more than a year ago, we have taken a number of concrete steps to address our health commitments to First Nations people.

For example, in September, with Vice Chief Gordon Peters, I unveiled a new \$243 million federal strategy to expand and strengthen existing health programs for First Nations and Inuit peoples.

We call this strategy **Building Healthy Communities**, and we are beginning to implement it in consultation with First Nations and Inuit communities.

Building Healthy Communities is intended to more fully address priority health issues identified during consultations with First Nations and Inuit communities and leaders. Toward this end, we have strengthened programs and increased funding in three critical areas -- solvent abuse, mental health and home care nursing.

In addition, we have taken steps to enhance and expand the transfer of health resources to First Nations and Inuit communities, at a pace to be determined by them.

I would like to take a few minutes to briefly expand on the program elements of **Building Healthy Communities**.

We are all too familiar with the need for action in the area of mental health. Under the new *Mental Health Crisis Management Program*, we will take that action by supporting a range of mental health services in conjunction with the affected communities.

We will provide First Nations and Inuit communities with the resources to more effectively manage and intervene in crisis situations.

Funds are also being provided under **Building Healthy Communities** to address the devastating problem of solvent abuse, which is reaching epidemic proportions in some Northern communities.

This issue, which is essentially a problem of young people, has captured the attention of the entire nation. We must take action now to avoid losing a generation of First Nations youth, with all the promise and hope they offer their families, their communities and Canada.

The *Solvent Abuse Program* will address this health challenge with a fuller range of initiatives than have previously been available.

The third priority need addressed through **Building Healthy Communities** is the growing demand for home care nursing in First Nations and Inuit communities. This shortfall has become particularly evident with the recent shift in focus by provincial and territorial governments from institutional to community care.

The *Home Care Nursing Program* will provide some financial support to communities to coordinate on-reserve patient care to meet the needs of persons discharged from hospital and those with acute illness. Funding will also be provided to ensure access to training so that safe and knowledgeable practices are used.

I was very pleased to be able to include enhanced resources to support the health transfer initiative as a major component of the **Building Healthy Communities** strategy.

Close to 100 First Nations are already controlling their own community health resources as a result of my department's transfer initiative. More than 200 others are involved in some phase of the transfer process. We will continue to work with these communities to complete transfer negotiations.

Also under the **Building Healthy Communities** strategy, funding will be made available for a new initiative called the Integrated Community Based Health Services to support communities not involved in the transfer process.

This funding will be available to establish and maintain community health management structures and for activities that support community health planning. Our objective is to create options to support these communities to better manage their resources in an integrated, community-based approach, which will lead to increased control.

My department will also be looking at ways to expand the transfer initiative to include *Non-Insured Health Benefits*, such as medical transportation and vision care. In fact, we are already working with the Assembly of First Nations to develop future management options. Many First Nations have asked that we begin negotiating agreements to assume control of *Non-Insured Health Benefits*.

Over the next two years, we will be testing a number of these options through pilot projects that will be implemented in close cooperation with First Nations. This will assist my department in seeking a mandate from Cabinet to transfer control of all *Non-Insured Health Benefits* to First Nations.

As you can appreciate, the **Building Healthy Communities** strategy has a very strong focus on collaboration.

These enhanced programs will improve our ability to work with First Nations to build healthy communities. In fact, First Nations will be full partners in the design and implementation of the new programs within the available financial resources.

This collaborative approach addresses our Red Book commitment to work in partnership with Aboriginal communities to provide them with the tools and resources necessary to tackle the physical and mental health issues they face.

Building Healthy Communities also directly addresses our Red Book commitment to work toward a future in which First Nations children grow up in secure families and healthy communities, with the opportunity to take their full place in Canada.

And it contributes meaningfully to our primary objective of building a new partnership with Aboriginal peoples that is based on trust, mutual respect and participation in decision-making processes.

One of the more specific commitments made in the Red Book is the promise to triple the number of bursaries and scholarships available through Health Canada for training Aboriginal health professionals.

In October, I announced that funding for grants and bursaries through the Indian and Inuit Health Careers Program will increase this year from \$100,000 to \$300,000.

This will enable between 25 and 50 additional students to participate in the program this year.

In these very difficult fiscal times, the Government of Canada has clearly demonstrated its commitment to increase the resources available for First Nations and Inuit health. The \$243 million allocated to the **Building Healthy Communities** strategy, for example, is four times the previous resources devoted to First Nations/Inuit health in the areas of mental health, solvent abuse and home care nursing.

Nevertheless, there is an ongoing need for government-wide fiscal restraint. As you know, a major review of federal programs is now under way, and my department is part of this process. While we cannot predict the future, we do know that the pressures on government funding will be enormous.

As a result of the 1994 federal budget, for the first time the Medical Services Branch of my department is having to operate within an envelope of resources for Indian health services.

This will present some definite challenges, but I am confident we can overcome them by working together. Although the budget will continue to grow over the next five years, so will demand. We will have to come up with new, more cost-efficient and effective ways to achieve our objectives -- and the best way to do that is through collaboration and open dialogue.

I can see from your conference agenda that you will be discussing a wide range of health-related matters over the next few days, including the issues of self-government and health care as a treaty right, for example.

As you know, work is already under way to determine how to implement the inherent right of self-government. In addition, the Red Book includes a commitment to develop a mutually acceptable process to interpret the treaties in contemporary terms.

My colleague, the Minister of Indian Affairs and Northern Development has the lead federal role in addressing these two issues. However, I can assure you that I will be actively involved in supporting the move to self-government, as well as in supporting any treaty discussion process established by Indian Affairs and Treaty First Nations.

In closing, let me wish you all a productive conference; one that arrives at new ideas and new approaches to First Nations health challenges. We share a common objective -- that is to build healthier families and communities. Thank you.



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Speaking Notes
for the
Minister of Health
the Honourable Diane Marleau



Press Conference on
World Forum on Physical Activity
Quebec City, December 9, 1994

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Ladies and gentlemen... I am very pleased to be here today.

The Government of Canada is proud to lend its support to the World Forum on Physical Activity.

A world first, this event has been made possible through the initiative of four major international partners: the World Health Organization, UNESCO, the International Olympic Committee and the World Federation of Sporting Goods Manufacturers. This undertaking is clear evidence of the importance they all attach to promoting physical activity.

Until very recently, physical activity was part and parcel of Canadians' everyday lives. Farm wives with large families certainly got plenty of exercise in a day and people didn't jump in their cars just to go to the corner for a newspaper!

Nowadays, our urban lifestyle and the demands of our modern society do not favour physical activity -- a situation with serious personal and social repercussions.

We know that physical activity and sports contribute to reducing the incidence of certain diseases and health problems: heart disease, colon cancer, osteoporosis, yet close to one third of Canadians are not involved in any physical activity.

We also know that participation in physical activity and sports have beneficial socio-economic effects, for instance: lower crime rates; improved environmental quality when people use cars less and walk or cycle more; the considerable economic impact generated by the Canadian sports and fitness industry.

The federal government supports the integration of physical activity with people's daily lives -- a measure that is both dynamic and preventive. We are focusing on raising Canadians' awareness of the consequences of inactivity, as well as on promoting living environments that are more conducive to physical activity.

These measures -- and many others -- are beginning to have some effect. More and more Canadians are making physical activity part of their daily routines.

To give a few examples: in a recent national survey, 39 percent of work places with more than a hundred employees report that they are now making workplace fitness programs available. Seniors are getting together in the mornings at shopping malls for a daily walk; students are meeting the Canadian Active Living Challenge in their schools; community leaders are setting up sports programs specifically for young women...

Other departments besides Health Canada are behind the coming Forum:

Foreign Affairs, Environment and Heritage. This combined support demonstrates the importance the Government of Canada assigns to promoting physical activity and sports, and to research in these areas. I am pleased to say that we have begun to make progress in this area.

I am sure that next May 21 that we Canadians shall come -- on bicycles, in canoes, in wheelchairs or on foot -- in great numbers to support our national and international partners at the opening of the first **World Forum on Physical Activity and Sport**.

I would like to close by congratulating those who have organized this meeting here today for the excellent job they have done.

Thank you.



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Speech / Discours

Speaking Notes
for
The Honourable Diane Marleau
Minister of Health

Special Senate Committee on Euthanasia and Assisted Suicide
Ottawa, December 12, 1994



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Madam Chair, I am pleased to have the opportunity to appear today before this Special Senate Committee. I would first like to express my appreciation to you and the Committee members for the work that you have undertaken. Euthanasia and assisted suicide are difficult issues.

I have followed with interest your activities over the last several months and the general direction that testimony has taken. I commend the Committee for assembling such a broad spectrum of witnesses. All bring an important perspective to a debate that has the potential to affect every Canadian.

I will of course bring the health perspective to this discussion, and will focus in particular on health at the end of life. My colleague, the Honourable Allan Rock, Minister of Justice and Attorney General of Canada, will be appearing before you on December 14th to discuss the legal aspects.

Many witnesses appearing before you have dealt with specific concerns, such as pain management, lack of knowledge about palliative care and lack of physician training. I will be dealing with these issues. But my first objective is to recast the discussion on more holistic terms.

I want to talk about what happens to individuals when they live the final phase of their life. I want to talk about the quality of their experience, and how we as a society can ensure that quality of life is maintained to the greatest degree possible in this important period.

From my perspective, the first question we should ask is whether a dying individual is adequately supported. Is that person given all options in terms of physical, medical, social and spiritual care? Is that individual receiving the most appropriate care? Are we respecting the care decisions he or she takes about how they lead their life in the final moments? Why are we so eager to jump first to the issue of individual autonomy and the "right to die" when we have so little detailed information on the circumstances that create the desire to hasten death?

Society has invested a lot in technologies that serve to prolong life. However, in these times of fiscal restraint, we may be forgetting about care and the quality of life when life is extended. As you know, some technologies maintain life but do not necessarily restore health.

Together, these aspects of social change are increasing the numbers of Canadians who are vulnerable in society. One of our first concerns must be the degree of security that people have as they approach death and dying. In the debate, we cannot overlook the vulnerable, the elderly, the disabled, the chronically ill and those who lack the capacity to make informed decisions about their futures.

There is a real risk that these populations would be made to feel more insecure if the social emphasis is on euthanasia and assisted suicide. It is human to fear death. A measure of our humanity as a society is our ability to prepare individuals for their mortality without diminishing their security as members of society.

There are few circumstances where the patient's condition has deteriorated to the point where euthanasia becomes an issue. However, concern is usually with deaths from chronic disease, such as AIDS and cancer, in which the individual is facing a prolonged deterioration.

Different societies have taken different routes to deal with this issue. We have seen the development of the hospice movement in the United Kingdom. The Americans are still, by and large, investing in high technology. The Dutch are experimenting with a more open approach to euthanasia, the results of which are just now being analyzed. I understand this may have slowed down the development of palliative care.

Canadian society has the obligation to evaluate the various experiences around the world, and to settle on a model or models that are right for Canada.

A key element in quality of care at the end of life is the availability of palliation. In the early 80's the palliative care movement in Canada "took off", and we saw the emergence of some support for the dying. However, the movement was uncoordinated at the national, provincial and local levels.

Some 10 to 15 years later, palliation is still not well established in many areas of the country; and we have not defined what palliative care is. In part, this is the result of society's reluctance to deal affirmatively with end of life issues.

I want to touch on ten areas requiring attention if the individual -- the focus of my concern -- is to be provided with high quality care at the end of life.

We need better diagnosis and prognosis. Too frequently, especially for

the elderly, diagnosis of illness is delayed and prognosis is either not fully understood or inadequately conveyed to the individual and the family and friends who must cope with the illness.

We need institutional development. There are not enough palliation centres especially outside of major urban areas. We need centres to coordinate community and home care, staffed with professionals with a sense of outreach and mobile forms of delivery.

Provider training is essential. The Canadian Nurses Association has stressed that when treatment ends, care continues. Physicians have a role to play in palliation, but they are not necessarily the key provider. We need fully developed teams of providers ranging from physicians to volunteer support networks to deal with the problems of end of life. We may even need to develop new specialties in this area.

Individuals should have a full range of choices. The medical model is not the best in many circumstances. Individuals are suffering from excessive treatment in many instances. We need to consider the appropriateness of treatment.

We should be thinking about alternative settings -- homes, community based projects, etc. Most Canadians still die in hospital. This is not a preferred setting for many people. Most individuals wish to die at home if at all possible, surrounded by family and friends. We need to consider how to make this possible.

Research into pain control and management should be a priority. While much has been accomplished in this area, we remain uncertain as to whether pain control in palliation can relieve the pain and suffering of all those individuals who are terminal. We need to know more about comfort and the supports that focus on time of administration of drugs and dosages. While modern medicine has the technology to relieve pain, it is sometimes too aggressive. It is necessary to support research into non-surgical, holistic and gentler methods of pain management.

We need to foster and strengthen partnerships among various providers so that a full continuum of care is available. There is a need to shift the focus of care away from the acute care setting and towards the community. Linkages have to be built between acute care, community care, home care, outpatient care and family care.

We need to better understand the role and responsibilities of the parties involved. As well, the individual and his or her family has to be front and centre and involved in the process. Too frequently, communication breaks down between providers, the individual and the family. The result is that the individual and the family feel alienated from the system that is providing care. Often, excess energy is devoted, at times of stress, by the individual and family members, to "making the system work for them".

Research on end stage disease and the process of dying is required. We do not know enough about end stage disease and how it affects the individual from the physiological and psychological stand points. Protocols about the transition from active treatment to other forms of care are underdeveloped. We also do not know enough about the interaction between the disease process and various supports such as nutrition. There are various rules of thumb in this area, with little consistency of application. This contributes to the uncertainty for patients and their families.

We need to concentrate on quality care at the end of life. As the federal Minister for Health, I am interested in working with my provincial and territorial colleagues and interested groups on a framework for future action in this area.

As you well know, it is not easy to discern what is right or wrong, what is just, what is fair and wholly compassionate. That is why we need to wrestle with these questions, and to promote public dialogue on *these* issues.

We do need, however, a good starting point. In my view, to focus only on euthanasia and assisted suicide would be to leave the debate about end of life fundamentally flawed and incomplete. The focus has to change. Care must be our most important concern.

Thank you.



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Speaking Notes
for
The Honourable Diane Marleau
Minister of Health



Before the Subcommittee on HIV/AIDS
Ottawa, February 8, 1995

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Mr. Chairman, I am pleased to have the opportunity to appear today before this new Subcommittee on HIV/AIDS. I would first like to thank you and the Subcommittee, for the work that you are about to undertake. This demonstrates to me the significant interest in HIV infection and AIDS among the members.

HIV infection is a multi-dimensional disease that forces all HIV/AIDS partners, including policy makers, to look beyond the boundaries of physical health. Issues such as poverty, violence, drug and alcohol use and human rights, all have to be addressed when dealing with this important issue.

In a decade of work against this epidemic, Canadians from all walks of life have together made a significant contribution to finding solutions to this disease. The transmission is preventable, but there is still no cure or vaccine for HIV.

In fact, so far, the HIV virus has outsmarted us all.

I understand that you have already received a comprehensive briefing by officials from my Department on Phase II of the **National AIDS Strategy**, as well as information on the status of AIDS in Canada.

Over the next couple of months, you will hear testimony from a broad spectrum of witnesses. I am sure that each of them will have an important perspective to share with the Subcommittee.

The mandate that you have received from the Standing Committee on Health is most appropriate as we are about to enter the third year of the current **Strategy**. It is timely to share current and future challenges and opportunities as they relate to HIV/AIDS.

I will, of course, bring the health perspective to this discussion and will focus in particular on three issues:

- ◆ first, this government's **leadership** and **commitment** to dealing with HIV/AIDS;
- ◆ secondly, the link between the **mandate** of the Subcommittee and the increase in the number of AIDS cases in specific populations; and finally,
- ◆ the significance of **partnerships**.

As Minister of Health, my mandate is to enable Canadians to maintain and improve their health. In addition, as Minister responsible for the **National AIDS Strategy**, I would like to assure you that one of my major commitments is to those affected and infected by HIV/AIDS.

There is no doubt that, over the past 15 months, we have shown strong leadership in the fight against AIDS on both the domestic and international fronts.

As you know, both the Prime Minister and I attended the Paris Summit on AIDS last December. This signalled to Canadians and other countries that Canada places a priority on eliminating this devastating disease.

Over the past decade, Canada has shown a strong commitment to international AIDS activities. In Paris, the Prime Minister indicated that Canadians were looking forward -- this year and next -- to the two major international conferences on AIDS. In Montreal this May, Canada will be hosting the Second International Conference on Home and Community Care for Persons Living with HIV/AIDS. And, in July 1996, the Eleventh International Conference on AIDS will be held in Vancouver.

Because the transmission of HIV/AIDS does not respect geographical boundaries, last year, prior to the Paris Summit, I discussed HIV/AIDS related issues in Washington with Donna Shalala, the U.S. Secretary of Health. Similar discussions were also held with other international colleagues at the 47th World Health Organization Assembly, in Geneva.

Here in Canada I met last September with the provincial and territorial Ministers of Health in Halifax when HIV/AIDS was on the agenda. All re-affirmed a strong commitment to eliminating this challenging disease through continued implementation of national and provincial AIDS programs. Next week, the Federal/Provincial/Territorial Advisory Committee on HIV/AIDS will be meeting to follow-up on issues identified by Canada's health ministers and experts in this field, such as funding for drug treatment.

HIV/AIDS is a priority for me. At the community level, I have had the opportunity to meet with health and social service providers, representatives from community-based organizations and researchers. Speaking with persons infected and affected with HIV/AIDS or those directly involved in the field also helps me to keep in touch with the changing face of HIV/AIDS.

Last month, I met with representatives from the five HIV/AIDS national non-governmental organization (NGO) partners (i.e., the Canadian AIDS Society, the Canadian Public Health Association, the Canadian Hemophilia Society, the Canadian Association for HIV Research and the Canadian Foundation for AIDS Research). Among the items discussed at this session, was federal funding for the **National AIDS Strategy**.

As Minister of Health, I regularly face pressures for increased funding on a range of health matters. Aside from HIV/AIDS, there are a number of critical issues requiring resources and priority attention. In these times of severe fiscal restraint, new funding is virtually impossible. Difficult decisions have to be made with respect to the allocation of existing funding.

Indeed, given the current fiscal situation, the challenge will be to achieve more with each dollar spent.

As you know, at the time Phase II of the **National AIDS Strategy** was announced, \$40.7 million annually was allocated until March 1998 for education and prevention; research; care, treatment and support; support to non-governmental organizations and co-ordination and collaboration.

Throughout the program review process all federal programs have been assessed to find out if they meet a continuing public need and if they are appropriate federal activities. This was in preparation for the upcoming budget.

While HIV/AIDS continues to be a priority for this government, its funding has to be examined like all other federal programs.

It is unlikely that new monies will be available for HIV/AIDS. The challenge is not to spend every strategy dollar, it is to spend every dollar wisely.

The **National AIDS Strategy** framework is designed to promote better health, research, education, community action, compassion, care, treatment and support. One important **Strategy** theme is **Enhancing Partnerships**. Sustaining current partnerships, while encouraging new ones, will be ongoing during Phase II. This means continuing to strengthen collaboration among a variety of players to maximize efforts against HIV/AIDS, avoid overlap and duplication and build on experience and successes.

Governments, at all levels, need to work with other partners. Community-based and non-governmental organizations, the research community, the medical profession, health and social service providers, the private sector, and persons living with HIV/AIDS have important roles to play.

As the private sector becomes increasingly involved in supporting HIV/AIDS activities, one of the challenges for all partners will be finding appropriate ways in which to further involve this sector.

I recognize that research must continue to be a vital component of the **National AIDS Strategy**. Nearly half of the **Strategy** funding goes towards research and epidemiological monitoring, including extramural research funded through the National Health Research and Development Program and the Medical Research Council in the areas of basic science, clinical science, epidemiology and social science. Last month, representatives from the national NGO partners met with departmental officials to discuss this important matter. The department is committed to facilitating and coordinating, with research partners and other stakeholders, a national research planning process for HIV/AIDS. This process will build on previous work and will help us formulate an on-going research agenda.

Despite the growth of research, new drug therapies, and the efforts of everyone involved, HIV/AIDS continues to be a multi-faceted disease which challenges our health care system and impacts on all areas of society.

In Canada, there are more than 2,000 new AIDS cases every year. This disease is spreading at different rates among various population groups.

What is becoming increasingly clear is that the HIV/AIDS epidemic follows the path of least resistance. Some of the major societal risk factors include belonging to a population which is living in poverty, which may be discriminated against and marginalized.

I am particularly concerned about the increase of AIDS in specific populations, such as women, intravenous drug users, Aboriginal populations and prisoners. I am also concerned that the highest overall number of new infections may still be among men who engage in homosexual activities.

HIV/AIDS is a preventable disease. To prevent the further spread of the epidemic in Canada we need to reach these vulnerable populations and encourage their protective behaviour.

By focusing on the role of poverty and discrimination and the spread of HIV, your deliberations can help to enhance HIV/AIDS prevention, care, treatment and support for disadvantaged individuals.

HIV/AIDS is an issue that society must address because it concerns all of us. Our collective task is to understand this disease and the challenges it presents.

We must continue to strengthen and build partnerships among key players. From the very beginning, one of the most effective ways to respond to the HIV/AIDS challenge has been through community-based participation. And this approach is central to Phase II of the **National AIDS Strategy**.

In the first year of Phase II, the federal government supported HIV/AIDS national partners with over \$3 million in core and project funding. Following reallocation of funds, the amount for the AIDS Community Action Program was increased to over \$8 million in 1993/94. This supported over 200 community-based initiatives across Canada.

Another of my priorities is to ensure that the limited HIV/AIDS resources are used effectively and efficiently throughout the remaining years of the **Strategy**.

As part of the **National AIDS Strategy's** mandate, my department will be undertaking a mid-term review of the **Strategy** over the next few months. Recognizing that no new monies will be available, one of the challenges of the review is to ensure that the strategy is achieving more results with each dollar spent.

This review and the report of this Subcommittee will help to identify challenges as well as strengthen responses to the HIV/AIDS epidemic through the remaining years of the current Phase of the **Strategy**.

I will continue to work with my federal colleagues, including the Ministers of Justice and Human Resources Development, and the Solicitor General, my provincial and territorial colleagues, members of the **National Advisory Committee on AIDS** as well as HIV/AIDS NGO partners. Focusing further on the role of poverty and discrimination as they relate to HIV/AIDS can only be done in collaboration with major partners.

I believe that working in partnerships with all stakeholders will help to find innovative and better ways to respond to issues related to HIV/AIDS.

To date, the federal government has played a major role through the **National AIDS Strategy** in addressing HIV/AIDS issues. We must continue, within our fiscal capacity, to demonstrate our national leadership.

Thank you.



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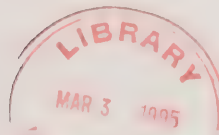
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Speech / Discours

Speaking Notes
for
The Honourable Diane Marleau
Minister of Health

"Beyond Caring"
National HIV/AIDS Nursing Mentors Project
for
Home Health Nursing
Ottawa, February 27, 1995



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Thank you, Ms. Roe, for your warm words of introduction. It is a pleasure to be here with you this morning, to launch this National HIV/AIDS Home Health Nursing initiative.

I want to congratulate the Victorian Order of Nurses for Canada for initiating this innovative Nursing Mentors Workshop. There is certainly no better teacher than experience. As the philosopher, Albert Schweitzer, once observed:

*"Example is not the main thing influencing others,
it's the only thing."*

While you have come to this workshop to learn and grow through the exchange of ideas and information, I want each of you to know that you have already set an extremely high standard in nursing.

Although your motto for this workshop is "beyond caring", I want to acknowledge the exemplary care you provide, week in and week out, which I know goes above and beyond the call of duty.

For almost a century now, Canadians have counted on the Victorian Order of Nurses for the highest quality of care and treatment. But I suspect there has never been a generation of VON nurses who have had to confront a task as difficult as the one which has prompted this workshop.

Like other disabling conditions, HIV/AIDS threatens the independence and social well-being of the people infected. Unlike other illnesses, a diagnosis of HIV is all too often accompanied by stigma, discrimination and rejection at the very time individuals need our support.

Instead of fear, you and your colleagues in the nursing profession offer compassion and commitment to people with HIV/AIDS and their families. You profoundly believe that every individual -- regardless of his or her illness -- has a right to expect, and receive, respect and dignity in their care.

I admire your devotion to people living with HIV/AIDS. You are an inspiration and a tribute to your profession.

I recognize the heavy toll the disease takes on caregivers. Despite your excellent nursing efforts, the rapid increase in research and new drug therapies, HIV/AIDS continues to be an epidemic with multiple consequences for infected and affected people.

I know it is essential that you, too, be nurtured and supported in this emotionally-demanding work.

Phase II of the **National AIDS Strategy** supports professional organizations in developing educational resources and enhancing the capacity of health care professionals to meet the HIV/AIDS challenge.

That is why my department is funding (\$170,000) this training and skills development opportunity. The project will also develop a portable resource kit for HIV/AIDS. It will contain teaching materials that will enhance the efforts of those involved in the HIV/AIDS Nursing Mentors network, to improve the quality of care and the quality of life of patients.

Everyone within the health system will benefit from this pilot project. As much as you can learn from each other, there is also much we can learn from your experience.

It is an interesting and, in some ways, ironic phenomenon. As we move into the 21st century, we find ourselves returning to the tried and true traditions of home nursing. Yet you are on the leading edge of one of the most crucial trends on the health scene.

In responding to the expressed desire of Canadians to be cared for in their own homes, you are demonstrating the advantages of offering quality health care in a home setting.

As health care providers on the leading edge of community-based care, you are illustrating it is possible to be innovative and productive, to do more with less, to increase quality without increasing costs.

Your successes in home health nursing are very encouraging because this is the direction in which Canada's health system is moving. And move it must.

You will be keenly aware that fiscal considerations are obliging us to re-evaluate our approaches to health spending. We are re-thinking what is really necessary and what we can afford, how quality care can best be delivered, where, and by whom, while still ensuring the needs and well-being of individuals and their families are addressed.

It is increasingly apparent that we should move health care as close as possible to the individual's home, primarily in response to the needs of individuals, but also as a way to cope with financial constraints. You are engaged in one of the methods of alternative health care delivery that I am discussing with my provincial counterparts and one which we fully endorse.

As leaders and role models within your communities, your proven track record in home nursing adds enormous credibility to the success of this approach.

The difficulty we all face, however, is keeping up with the staggering pressures imposed by HIV/AIDS in the face of increased demands and limited fiscal resources.

Clearly, the challenges are great. We are only beginning to understand and address the complex dimensions of this disease, yet the casualty figures continue to climb. There have been an estimated 15,000 cases of AIDS in Canada to date. There are an estimated additional 27,000 Canadians who are living with HIV and we expect 15,000 of them to develop AIDS by the year 2000.

At the time Phase II of the **National AIDS Strategy** was announced, \$40.7 million annually was allocated for education and prevention; research; care, treatment and support; assistance to non-governmental organizations and co-ordination and collaboration.

I want to assure you HIV/AIDS remains a priority for this government. We will undertake a mid-term review of the **Strategy** over the next few months, to ensure, in part, that the strategy is achieving the best result with each dollar spent. We must accept that no new monies will be available.

And that is why this workshop is so important. Increasing our ability to deliver home nursing care to people living with HIV/AIDS is essential to our efforts to respond to the needs of infected individuals and their families.

The creation of a national network to provide on-going support and peer consultation to nurses working with HIV/AIDS patients will ensure we remain responsive to the evolving nature of HIV disease and up-to-date on the most appropriate care and treatment approaches. This dynamic new network will contribute to our collective effort to provide optimal care for persons with HIV/AIDS.

I have no doubt each of you will walk away from this meeting strengthened and motivated to face the tremendous challenges ahead. Solutions may not be easy but they are not impossible. I am convinced that, through the on-going commitment of concerned professionals like you, we will respond effectively and compassionately to the needs of those living with HIV and AIDS.

Thank you.



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Speaking Notes
for
The Honourable Diane Marleau
Minister of Health

Canadian Hospital Association
Annual General Membership Meeting
Ottawa, March 17, 1995



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06/95

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Ladies and gentlemen, good morning. Thank you for inviting me to speak to you again this year.

What I want to talk about, of course, is Medicare and the *Canada Health Act*. I want to explain how and why this government supports Medicare and, most important, how and why we will continue to support it. I can't imagine a more important group to speak to on this issue, since it is you who ultimately manage the largest component of our health care system.

The federal budget tabled last month has been one of the most widely supported in Canadian history. But I have to acknowledge that, as a result of the budget, some people have questioned this government's commitment to health. They have questioned whether we will continue to have the capacity to maintain a national system. And they question whether we have the will to uphold the principles of the *Canada Health Act*.

First, let me tell you, dire predictions that the federal government will not be able to uphold the *Canada Health Act*, and that Canada's health care system will disintegrate as a result of this budget, do not stand up to a good reality check.

Let's deal right away with the *Canada Social Transfer*. Contrary to what you might have read, or heard, the establishment of the new Transfer will not diminish, weaken or erode the strength of our health system.

The Budget speech was clear on this. Mr. Martin said: "No change will be made to the *Canada Health Act*." And let me be equally clear. There is no change in the government's commitment, or in my own commitment, to uphold and enforce the principles of the *Canada Health Act*. As the Prime Minister said in Saskatchewan on Wednesday, "For Canadians, these principles are non-negotiable."

In fact, to confirm our intention to remain active in enforcing the *Canada Health Act* principles, when we introduce the final enabling legislation, we will use the word "health" in the title.

The new transfer arrangement will be a block-funding arrangement. That may worry some people. But let's not forget that block funding for health and post-secondary education is 18 years old.

The Established Programs Financing funding mechanism, put in place in 1977, is a block funding arrangement. In it, there is no requirement for provinces to spend the money on health. What there is -- and what was nailed down in 1984 when we passed the *Canada Health Act* -- is the requirement that provinces deliver health care services in compliance with the five principles of the Act or face a deduction from the money transferred to them.

Some worry that under current thinking about the *Canada Social Transfer*, no clear dollar amount will be denoted as a "health" portion. Again, it is worth emphasizing that under EPF there was no longer a relationship between what was called the "health" portion and actual provincial expenditures. It was merely an historical artifact based on national averages twenty years ago.

Nothing in the Budget will change our technical ability to enforce the *Canada Health Act* principles. The enforcement mechanism remains the same. If deductions from transfer payments are necessary, they will be made. They will be made from the cash portion of the new *Canada Social Transfer* or, if necessary, from other cash transfers.

In fact, the new transfer arrangements help deal with the "political" problem, noted by some, that the EPF cash will eventually run out under current arrangements. The *Canada Social Transfer* considerably extends that date.

So, I believe that the *Canada Social Transfer* will not reduce the federal ability to enforce the principles. But, if you want to truly understand the government's commitment, you have to understand why we will continue to enforce the *Canada Health Act* principles, and why we are convinced that this enforcement is essential to both our health and our economic well-being.

We will enforce them because these principles -- universality, accessibility, comprehensiveness, portability and public administration -- are ultimately rooted in our common values -- Canadian values such as equity, fairness, compassion, and respect for the fundamental dignity of all. We will also enforce the principles of the *Canada Health Act* because they support an economically efficient health care system.

The principles of the *Canada Health Act* are not just words. They have meaning -- meaning that is decades old and still vital. In their totality, they assure both the provision of quality health services to all and the containment of costs. It is useful to remind ourselves of how they work together to produce an effective system.

The first principle is universality. All residents in a province must be insured by the provincial health plan if it is to receive federal support. It sounds simple, doesn't it? But, let us look at its real meaning.

What it really means is that we, as Canadians, believe we all must have access to services. People cannot be de-insured because they might be costly for the system to cover. They cannot be turned away at the hospital door because, for example, they have not paid their quarterly tax bill -- or even their provincial premium. If we need health care, we will be treated the same as everyone else. This is what Canadians mean by equity. This recognizes our dignity as human beings. This demonstrates that we are a fair and compassionate people.

Accessibility on uniform terms and conditions is the second principle. What does it mean? It means that we should not face any financial barriers in receiving health care -- no extra-billing, no user charges, no facility fees, no up-front cash payment. If the service is medically necessary, we will get it at a time defined by medical considerations, not by money.

Underneath, the consideration of universality and accessibility means that we practice what we preach. We say that all Canadians are to be treated equitably, and we ensure that they will receive care based solely on need.

Next comes comprehensiveness. This principle recognizes that Canadians have a range of health care needs and that those **needs** should be met.

Delve deeper, however, and you will see that comprehensiveness again means we practice fairness. It would not be fair to insure only some medically necessary services and not others. We cannot, and should not, try to choose at the federal level which services are medically necessary, but we should and will continue to interpret the *Canada Health Act* as requiring coverage of all medically necessary services.

We will continue to take the position that if a province insures any part of the cost of a service, that is an indication that they believe it to be medically necessary and all of the costs must be covered.

Justice Emmet Hall, in his original Royal Commission on Medicare, recommended a very comprehensive package. Liberal governments of the 1960s, '70s and '80s accepted the concept of comprehensiveness, although not quite as broad a concept as Justice Hall's. I'm here today to tell you that Liberal governments in the 1990s will not turn their backs on this principle.

But we must also be reasonable. We do not, and I will not insist that provinces cover services such as cosmetic surgery, and we must, as a practical matter, allow provinces some latitude in defining this comprehensive package. But we must also be aware that de-insuring services leads towards a privatization of coverage of medical services and that privatization of coverage leads to less cost control, not better cost control.

We will be vigilant lest any province, in an excess of enthusiasm to reduce provincial budgets, de-insures services which are considered to be part of a comprehensive range of medically necessary services.

And let us also remind ourselves that there is something that comprehensiveness does not mean. It does not mean uniformity. It does not mean that Canadians in one province should have their health needs met in exactly the same way as in another province. All Canadians will have their health needs met, but there can be, and should be, some variety across the country in how that is done.

This leads me to some comments on uniformity and innovation. Put simply, too much uniformity stifles innovation. Innovation is needed to make sure that the health system continues to adapt to changing circumstances. Pressures on the health system are always changing. Changing demographics, changing technology, changing fiscal situations. The comprehensiveness principle, interpreted properly, recognizes that health systems must be adaptable, and it allows for innovation.

The delivery of health care is a provincial responsibility. Canadians respect this and the diversity that this brings. In the end, we all benefit from diversity because a successful innovation developed in one province can be borrowed and adapted by others. Look at the CLSCs in Quebec. The extra-mural hospital in New Brunswick. The quick response teams in British Columbia.

Innovation has never been as important as today. During these difficult fiscal times, the health system must adapt and change. And, it must do so at a faster rate than ever before.

The fourth principle is portability. It means that Canadians maintain their health plan coverage when they travel or move.

The portability principle, however, is rooted in one of the fundamental elements underpinning our federation. Portability recognizes our right of mobility. Canadians are free to work and travel anywhere in the country without fear of losing their health insurance coverage.

It would not be fair to say that we are citizens of Canada no matter where we live, and then put up a barrier to moving within Canada, especially a barrier that concerns the most vital of a person's interests.

Portability is what makes our national health insurance system truly "national." Each separate health insurance plan may be provincial in origin, but is recognized nationally -- in every province across the country.

The fifth, and final, principle is public administration. Our health insurance plans must be operated by provincial governments on a non-profit basis.

I believe this principle too often gets short shrift. It never seems to get the same attention as the others. But, it should. It is at the core of our ability to contain costs in the system and thus to deliver quality care at an affordable price.

Public administration is the means by which we ensure all of the other principles. When health insurance is operated and funded through governments, we can guarantee that health care is universal, accessible, comprehensive and portable, because we have direct control over it.

Through public administration, we also demonstrate our collective responsibility for our health care system. We must never forget that privileges and responsibilities go hand in hand. Canadians are responsible for paying for their health system. We do it collectively, through our taxes. We all pay so that everyone can benefit according to need. We have agreed to provide this most essential of human services together, and we must not lose that.

Public administration also demonstrates something else about Canadians -- our pragmatism. We want value for money, and administering health insurance publicly is the best way to get it in health care. We need only look to the experience of our American neighbours to compare the efficiency of public administration to private administration.

A 1991 report of the United States Government Accounting Office said that "If the universal coverage and single payer features of the Canadian system were applied in the U.S., the savings in administration costs alone would be more than enough to finance insurance coverage for the millions of Americans who are currently uninsured."

It is one of the uncelebrated miracles of Medicare that public administration is much better, and far more efficient, than private administration.

Not only does public administration make sure that more of our health care dollars go toward patient care, governments can be more successful than the private sector in keeping health costs under control. In 1993, we spent about 72 billion dollars on health care. This represents 10% of our Gross Domestic Product. The public component of that 10% has been growing at less than 2%. Compare that to private health spending which has been growing at 6.4%.

In fact, over the last three years, per capita spending on the publicly administered part of our system has been declining. And since our GDP has been growing, it is safe to predict that in 1994 and 1995, we will come in with below 10% of GDP devoted to health care. I know that you have helped make that happen. In fact, you've probably helped more than anyone else. I want to credit you for this good performance.

That's how important you are in preserving and improving our health care system. You are on the front lines. You have the knowledge, the understanding and the skills essential to improving the efficiency and effectiveness of the system. You are the leaders in your communities when it comes to improving the system. You have chosen careers in the service of the public -- as have I -- and I hope we can continue together to preserve our most vital and valuable social program.

Saying that the federal government wants to maintain the principles of the *Canada Health Act* is not enough. We have to know we have public support. As a politician, I cannot escape the will of my constituents. They put me in office, and they can take me out. The same is true for the Government. And Canadians are all saying one thing to us very clearly: they want us to enforce the principles of the *Canada Health Act*.

In Canada's health care system there are no first or second class citizens. We enjoy rights and privileges as Canadians that are the envy of the world. We can live wherever we want in Canada, and have access to health care when we need it.

The many values that make up Canada's social fabric are reflected in the five principles of the *Canada Health Act*. They reflect the Canadian concern for justice and equity in our health care system and they are not going to disappear. Canadians, including, I'm sure, every one in this room, will not allow that to happen.

Thank you.



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Speech / Discours

Speaking Notes
for
The Honourable Diane Marleau
Minister of Health

Youth Health Assembly
Vancouver, March 20, 1995



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Ladies and gentlemen, young people.

Youth is a time of making choices. Some of the most important ones made by young people relate to their lifestyles and health – not just in the physical sense, but their emotional and mental well-being as well. While there can be fairly immediate impacts from some choices, the full impacts of many decisions may only become apparent in later years.

A generation of people now in their forties, fifties and older are facing the health implications of decisions made twenty or thirty years ago – to smoke, to drink, to avoid exercise. Given the information and the social conditions of the time, it is not surprising that many of us did not always take the healthier option. Today's young generation has the resources, the information and the environment to help them make wiser choices. Many are doing so. Young people form the population segment with the best physical health.

However, the stark reality is that others are not making choices that reflect long-term emotional and physical health. For example, an Ontario survey of drug use suggests that 1,700 high school students are at risk of HIV infection because they share needles. A national survey says that 60 per cent of 15 year olds have been drunk at least once. Another reports that one out of eight 15 to 19 year olds and one in seven 20 to 24 year olds are addicted to tobacco.

Finding ways to address these and other youth health concerns is a goal of this Assembly. The three events that make up this Assembly are each important in their own right. Collectively, they are essential vehicles for progress across a spectrum of youth health issues. For that reason, I am pleased to welcome delegates to the largest meeting of its kind ever. I also want to welcome you to one of Canada's most beautiful cities, Vancouver.

The theme for this Assembly, youth empowerment, is a well-chosen one. With the few minutes available to me this morning, I want to talk about its importance, and the ways we are making it a reality in federal health programs and services.

Let me begin by asking if today's young people feel empowered? Do they feel that they exercise a reasonable degree of control over their lives? The simple answer is no. Does it matter? Yes.

Surveys and other research show that young people often feel that society does not accord them real respect. Their perceptions, opinions and needs are discounted. They tell us they have little ability to influence the decisions that shape their lives at even the most simple level.

To at least some extent, this affects the health and lifestyle decisions that many of them make. The young people here will tell you how important it is to be involved in the decisions that affect them. I am certain that any of them can list many examples of well-meant health initiatives that were ineffective simply because they did not take into account the culture, intelligence and situation of youth today.

A climate of respect fosters better health choices -- for youth just as for all people in society. Youth with a greater sense of empowerment are more likely to make positive choices. Conversely, youth who see themselves without a future, without power, at the edges of society, are at greater risk. Faced with problems that are far more immediate, they may see little reason to be concerned about health decisions with possible impacts years away.

There is one fundamental implication of this situation for health providers, governments and institutions. It is that our programs and services must reflect the needs, perceptions and realities of young people if they are to have any real success.

This understanding has had an impact on the approaches the Government of Canada takes to the questions and issues of youth health. At Health Canada, we have taken many steps designed to let young people exercise real influence on our strategies. We have enabled youth to talk to the people and institutions that provide services to influence their directions. Let me offer some concrete examples of this attitude at work.

High risk youth are an important focus of **Canada's Drug Strategy**. Under the Strategy we have found ways to enable these youths to influence programs and services better. For example, we found that in many cases they were interacting with the people who provide services solely as clients. They seldom sat down with each other to discuss how effective a program really was.

We needed to improve the relationship between youth and service providers. So we brought them together in three regional workshops. Although we are only a short way into this initiative, it has already proven to be valuable in breaking down some barriers and clearing misconceptions among both groups.

More importantly, it has helped make the processes that service providers use more consistent with the needs and interests of clients. It has helped open their eyes to the potential of these people as individuals. The youths themselves have often grown through this activity.

Our **Tobacco Demand Reduction Strategy** uses a wide variety of tools to cut tobacco use among Canadians, and certainly among young Canadians. An increasing number of these are based on peer-led models.

For example, our **Child-to-Child** program is being introduced to Aboriginal children between the ages of nine and twelve. This program supports children and youth in identifying, researching and addressing health issues, including tobacco use. We believe that this model will expose them to the facts in an effective way.

A good example of this approach to empowerment can be found in our HIV/AIDS prevention work. **Skills for Healthy Relationships** is a model curriculum on HIV/AIDS prevention and healthy sexuality. We have worked with the provinces and territories to develop and implement it.

Its focus is on helping young people gain the knowledge and develop the skills in three areas: abstinent behaviour, the use of protective measures by sexually active youth, and compassion and tolerance. It does not just tell people the facts. It helps them learn how to be assertive in the face of pressures exerted on many teens.

The evaluation of **Skills for Healthy Relationships** have been very positive so far. Those who participated are more informed. Their attitudes, skills and behaviour have been significantly affected for the better.

As well, the **National Forum on Health**, which was launched last fall by the Prime Minister, will be hearing from some of this Assembly's Canadian participants. The **National Forum on Health**, as some of you may know, was created to suggest ways of improving the health of Canadians and the efficiency and effectiveness of health services in this country.

Forum members will be meeting on March 25 with some of you during a workshop on "Visions of a Healthy Young Person in Canada", organized by the Canadian Youth Foundation and the Forum. Members will be there to listen to your views and to discuss their goals. As the Vice-Chair of the Forum, and in my capacity as Minister of Health, I am looking forward to hearing the members report on that workshop.

There are numerous other examples I could cite. Indeed, many of our empowerment-driven initiatives are represented in the workshops and displays at this Assembly. We also know that this is increasingly the approach taken at an international level. The World Health Organization, the Pan-American Health Organization and UNICEF all recognize the importance of empowerment. We are pleased to have them represented here to work with us as co-sponsors of this Assembly.

Let me close my remarks by pointing out that, for all our concerns, this is a smart generation of young people. In general, they have the facts and they understand them. Most are using those facts to make the healthier choices that many older people did not. What they ask, is that we listen to them before we try to address what we believe to be their needs.

This Assembly is a step in that direction. With our ratification of the **United Nations Convention on the Rights of the Child** in 1991, Canada took a first step in a series of new initiatives towards the goal of a better tomorrow for children and youth, both domestically and internationally. This Assembly is a prime example of Canada's commitment to the Convention and our efforts to ensure that young people grow up in an environment conducive to their complete development.

I know the challenges and the joys of watching adolescents learn to make the choices that lead to adulthood. Health choices are one of the most important. That is why, as both the mother of three young people and as a Minister concerned with the health of millions more, I have declared this week **Youth Health Awareness Week** in Canada.

The Youth Health Assembly is a central part of this week in Canada. It is a chance for people to build on successes, to learn from each other, and to return with new ideas and new energy, perhaps to meet again soon.

I wish you all the best for a successful Assembly. Thank you.



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Speaking Notes
for the
Minister of Health
The Honourable Diane Marleau

Launch of the Palliative Care Module
"A Comprehensive Guide for the Care of Persons with HIV Disease"
Toronto, April 10, 1995



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Thank you, Mr. Freedman, for your kind introduction.

It is a pleasure to participate in the launch of the "*Palliative Care Module -- A Comprehensive Guide for the Care of Persons with HIV Disease*" -- and to meet the many dedicated individuals who made it possible.

I want to congratulate the project's co-chairs, Dr. Frank Ferris of Mount Sinai Hospital and Mr. John Flannery of Casey House Hospice, for taking such a proactive approach in the development of this module.

By bringing together an outstanding team of palliative care specialists -- including administrators, chaplains, nurses, pharmacists, physio- and occupational-therapists, physicians, social workers, volunteers, persons living with HIV/AIDS, partners and families -- you have contributed enormously to our knowledge of successful strategies in caring for Canadians with advanced HIV disease.

The *Palliative Care Module*, initiated and funded by Health Canada's AIDS Care, Treatment and Support Unit, has been developed to provide guidance to caregivers on HIV/AIDS care and advice on treatment and support for patients in the advanced phase of their HIV disease. It will be especially helpful to health care and social service professionals and members of the affected communities who are new to the palliative care of patients living with HIV or AIDS.

The module is the fourth in a series of resources funded under the **National AIDS Strategy** and is a welcome addition to our earlier endeavours -- which include educational clinical modules aimed at caring for adults as well as infants, children and youth with HIV disease -- and an educational module for nursing care of persons living with HIV/AIDS.

At the time Phase II of the **National AIDS Strategy** was announced, 40.7 million dollars annually was allocated for education and prevention; research; and care, treatment and support, assistance to non-governmental organizations and co-ordination and collaboration.

Phase II focuses on promoting better health, understanding, care, treatment and support for those living with HIV disease.

HIV/AIDS remains a priority for this government. But financial considerations force us to re-think **how** quality care can **best** be delivered while ensuring the quality of life of those living with HIV and AIDS. We look to those people providing the health care and social service to help find solutions.

One of our key priorities is partnerships with professional organizations and representatives from the affected communities to develop educational resources that will enhance the capacity of health care and social service professionals to meet the challenges HIV and AIDS present.

I believe it is essential that caregivers be supported in this physically and emotionally-demanding work, because I recognize how daunting your task can be. You have my unending respect and gratitude for the tremendous work you do. I admire your compassion and your determination to provide optimal care to individuals living with HIV and AIDS, as well as your dedication to ensuring they live their last days with dignity, comfort and access to the support of their family and friends.

As you know, the challenges in HIV/AIDS care are great. In spite of the exceptional efforts of everyone in this room, despite the rapid increase in hopeful research and new drug therapies, HIV/AIDS continues to be an epidemic with enormous consequences for both infected and affected Canadians.

There are an estimated 27,000 Canadians living with HIV and we expect 15,000 of them to develop AIDS by the year 2000. As we enter the second decade of HIV disease in Canada, the demands placed on palliative care providers will be even greater.

Canadians living with the illness come from diverse social, economic and ethnic backgrounds, which makes the delivery of appropriate care more complex.

Health care and social-service professionals and community HIV caregivers are required to provide an innovative range of culturally-sensitive and individualized services -- from respite care for partners and spouses, to adoptions and alternate child care for HIV-positive children, to bereavement counselling for loved ones left behind.

The multidisciplinary nature of this Palliative Care Module reflects the varying perspectives necessary to truly address the care needs of persons living with HIV/AIDS.

It creates linkages among the various disciplines and AIDS service organizations, building on the many strengths, and encouraging the exchange of new ideas and information.

I believe this palliative care module will go a long way toward meeting the learning needs of health care and social service providers, equipping them with the necessary skills to meet the many challenges.

I am confident this valuable new resource will quickly prove to be beneficial to palliative care workers across Canada.

I am equally convinced that, through the on-going commitment of concerned people like you, we *will* be better able to respond to the needs of Canadians living with HIV and AIDS.

I am proud that Health Canada has been able to assist in the advancement of the care, treatment and support of Canadians living with HIV and AIDS.

Before concluding, allow me a moment to reiterate a message I would like all Canadians to hear from the Minister of Health.

The federal government is, as I am, committed to maintaining a universal, publicly-funded health system. This means upholding the *Canada Health Act* and the five principles on which it is based.

Because of the *Canada Health Act*, we enjoy rights and privileges as Canadians that are the envy of the world. The five principles of the Act work together to produce an equitable and efficient health system. They are a reflection of our commitment to all Canadians and to finding answers across the spectrum of health issues. Today's launch of a new Palliative Care Module underlines that commitment. I congratulate you on your initiative in this regard.

Thank you.



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Speaking Notes
for the
The Honourable Diane Marleau
Minister of Health

Canadians for Health Research 4th Annual Salute to Excellence
Ottawa, April 26, 1995



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Thank you for inviting me to be a part of this evening's festivities.

I am delighted to be with you, to applaud the accomplishments of Canada's researchers. Every one of you, representing diverse disciplines in every corner of the country, is to be commended for your innovative work. Each individual here this evening represents a vibrant research community making vital contributions to Canada's health system.

I want to congratulate Canadians for Health Research on initiating these annual awards. An event such as this enables us to honour research excellence and to recognize the organizations which fund it. It also provides a forum for scientists and representatives from the voluntary sector, industry and government to share ideas and discuss issues of mutual concern and interest. I am confident these awards will encourage even greater achievements in health and medical research in the years to come.

I am especially pleased that the **National Health Research and Development Program** of Health Canada is receiving special recognition tonight. I especially want to acknowledge the many contributions Canadians for Health Research have made to the **NHRDP** over the years, and to thank you for choosing this forum to help us celebrate **NHRDP's** 20th anniversary.

Those present will know that for the past two decades, **National Health Research and Development Program** funds have supported leading-edge research in this country. Through this program Health Canada has sponsored over 2,000 researchers in the public health and health services field.

The knowledge we have gained has had a direct and positive impact on the delivery of health care in Canada and on the health of all Canadians.

Although I could not begin to list our many activities, may I take this opportunity to say that I am particularly proud of our research efforts focusing on AIDS, seniors issues, tobacco, alcohol and drug abuse, as well as women's health issues, such as the Canadian Breast Cancer Research Initiative.

We are celebrating successes and I should point out that this program is not alone in enjoying a special birthday. The **Medical Research Council**, the major federal agency responsible for biological and medical research, is also celebrating its 35th birthday.

Over the 35 years since, MRC-funded scientists have made major contributions to the advancement of biomedical research in Canada and toward improvements in **diagnosis** and **treatment** of diseases.

These achievements are many. They include funding the development of the heart pacemaker, prevention of Rh disease in infants, artificial kidneys, joints and blood as well as organ transplant advances, brain surgery, cancer treatments and the identification of genes responsible for diseases such as cystic fibrosis and muscular dystrophy. All Canadians can be proud of these accomplishments.

I am gratified that the MRC decided, last year, to open its mandate to all health research. I look forward to a close relationship between Health Canada and the MRC to address the critical issues in the health field.

I would be remiss if I did not mention one other noteworthy anniversary. This week marks the launch of the successful, two-year public awareness campaign by the Schizophrenia Society of Canada and its affiliate, the Canadian Alliance for Research on Schizophrenia. It is another commendable example of the reputable work being done by Canada's research community.

Successful partnerships are key to the success of many of these research projects. I am sure we all recognize that progress results not just from individual accomplishments, as significant as they are, but by building on each other's knowledge base. Discoveries often develop as a result of taking someone else's study that next step forward.

And that is what I hope each of you will continue to do. I encourage Canadians for Health Research, its patrons and benefactors to push beyond the traditional boundaries of health and medical research. I would like to see you broaden your research base to move us further ahead in our understanding of the determinants of health.

We know that issues such as work, social support and income play a pivotal role in an individual's well-being, but we do not yet know enough. We are increasingly aware, however, that illness prevention and health promotion activities are producing dramatic improvements in the overall health of Canadians.

In order to meet the challenges of today and tomorrow, Health Canada appreciates, indeed depends upon your support in examining and seeking action on the critical determinants of health.

We also need to work harder, collectively, to ensure this invaluable information makes its way to the Canadian public. For, as Aristotle observed over 2000 years ago,

*"With regard to excellence, it is not enough to know,
but we must try to have and use it."*

It is essential that the benefits of research advances are made available to Canadians and are applicable to our everyday lives.

I want to congratulate Canadians for Health Research for highlighting this issue this year. I am impressed that, in keeping with your mission to "further understanding and communication among the public, scientific community and government" you are recognizing the importance of raising the public profile of health research by honouring a science journalist.

Stephen Strauss and *The Globe & Mail* have performed a worthy public service by providing readers with vital information about progress in health and medical research. This sharing of information is something we **all** must continue to do.

Given the dedication of the Canadian research community assembled here, I am confident we will achieve that objective. And I have no doubt there are many more breakthroughs on the horizon.

I wish you every success as you carry on with your important work.

Thank you.



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Speaking Notes
for the
Minister of Health,
The Honourable Diane Marleau

Sudbury Life Underwriters Association
Sudbury, April 28, 1995



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Ladies and gentlemen,

Medicare has a high profile in Canadian society. It is a program that touches all of us. It is a program everyone has an opinion about. But at the same time, many people do not know the whole story about medicare.

They understand that it represents some important Canadian values. What they may not understand is the powerful and objective economic arguments for the system we have in place now. They may not realize how much it contributes to our overall competitiveness in the world.

Today, I want to talk about the benefits of our single-payer system of health insurance to Canada's economy. I want to do this because we are seeing people start to promote a two-tier approach to health care in our country.

Advocates of better care for the rich often base their claims on economic arguments. Usually, they mangle both the facts and the economics. I want to set the story straight. And I can think of no better audience than people who understand insurance as well as you do.

Let's start with one fact. Health care is never free. Someone has to pay, public or private sector. Either way, there is an impact on the economy. Money spent on health care cannot be spent on something else.

Let's add another fact right away. There is no direct relationship between increased health care spending and health outcomes. Health is determined by a number of factors of which health care is only one. The environment within which we are raised and live is another. We don't necessarily gain better health from extra health care spending.

With those two facts, it is clear that controlling health costs makes sense for both the public and private sector. The need is to spend money wisely. Our medicare system, through federal-provincial funding covers 72 percent of total health spending in Canada. This gives us a much greater ability to control costs than the system in the United States.

Take a look at this graph. It shows the share of Gross Domestic Product that Canada and the U.S. have spent on health care over the last 25 years or so. Canada's national health insurance plan was completed in 1972. Canada and the U.S. used to have similar health insurance systems. We also had similar rates of health spending, approximately 7.5 percent of Gross Domestic Product or GDP. But since then, the lines have diverged in Canada's favour. We have done a better job of controlling health spending.

Last year, Americans spent more than 14 percent of GDP on health. We spent about 9.7 percent. And yet, whose citizens are healthier? Indeed, whose economy is growing faster?

Let me offer two reasons for these financial benefits. The first is that our system has enormous economies of scale and much lower overhead costs.

We have one organization in each province that provides standard insurance coverage to all residents. No risk rating is needed. Payments to providers are simple. Financing the system is streamlined. All mean lower costs.

The impact? Researchers at Harvard University found that Canada spends only 1.1 percent of our Gross National Product on health care administration. If we spent as much as the U.S. does on administration, health care spending would increase by \$18.5 billion. The United States spends about two and a half times that much. We only need to look to the American two-tier model to recognize that increased spending does not guarantee improved health.

The second reason we have a better ability to control costs is the fact that there is only one major buyer in our provincial insurance schemes. Governments have tremendous bargaining power in negotiating the costs of service. They can set and enforce global budgets for hospitals and physician services. And they have.

That takes me to this second graph. It shows how effective public sector spending controls on health have been. Since 1992, public health expenditures have been declining.

This graph also shows that private spending has not been brought under control. It continues to grow at a rate of more than 6 percent per year. The private sector does not have the same ability to control its global share of health costs.

These and other factors save our economy 30 billion dollars a year in comparison with U.S. levels of health spending.

Who gains from that 30 billion in savings? We all do, but at the head of the list is Canadian employers. For Canadian industries that face American competition, Medicare is a clear benefit. A study by the Agri-Food Competitiveness Council looked at businesses with operations on both sides of the border.

The conclusion -- employee health and social benefits cost American employers anywhere from three to five times more than Canadian employers pay. And companies such as Ford, Toyota and Chrysler have made that one important reason to invest in Canada instead of the U.S.

Canada's labour market is another winner. A competitive and efficient labour market requires that workers be able to move freely between jobs. Many, many American workers will not change jobs because of problems with health insurance. That costs employers. It costs workers. It costs the economy. It makes the labour market less efficient in a way we do not experience here.

Our economy wins in another way. We are learning that societies that enjoy good levels of health, with low levels of disparity, are likely to grow faster than ones with greater health inequalities. Health is an investment in productivity. It's just good economics.

And that takes me to my final point. I have noticed that the people who call for a two-tier health care system often trot out the same idea. "The government doesn't exercise this kind of control over markets for food or shelter," they ask, "so why health?"

Why? Because health is not a commodity like food or shelter. It does not have the same market features. Think about it. When we move to Sudbury, we have a very wide range of housing options to choose from. We can rent a small room. We can buy a large house. Money is only the first factor that affects our decision, after that we also exercise our personal taste and preferences.

The same goes for food. Each of us has the information to put together as healthy a diet as we want. We have the information to make our food purchases as simple or gourmet as we would like, and can afford. There are many places we can buy our food. Food and shelter are typical markets.

Health care is quite different. Let's say you have a severe pain in your abdomen. Let's say there is no insurance. Just how are you supposed to be the informed buyer that first year economics courses at universities talk about?

You can't really shop around. You have little ability to see a link between price and quality. Treatments improve all the time, so old information you might have is probably out of date. Your budget does not really matter. You cannot exercise your tastes or preferences. You have to take the professional advice of your doctor and pay whatever is asked, even if this means incurring huge debts. If you cannot pay, you forego treatment.

It is simply wrong to claim that health care would work perfectly in a free market. You do not buy an appendectomy the way you buy dinner. Getting cancer treatment is not like renting an apartment.

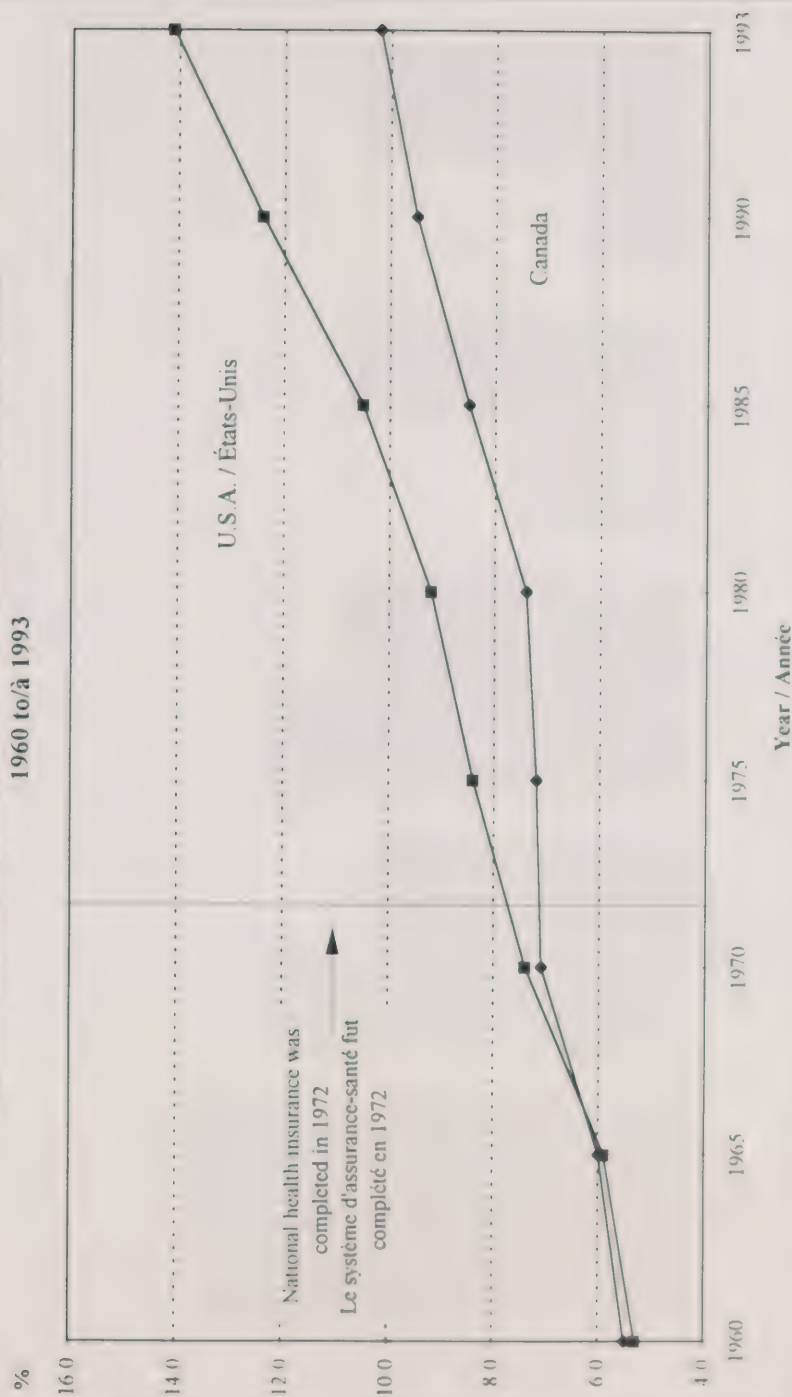
Canadians understand this difference. We have agreed to pool our risk across society. We have agreed to let governments work out fair prices as the buyer on our behalf.

Let me conclude with this message. The health of Canadians is no place to test fuzzy theories based on shaky economics.

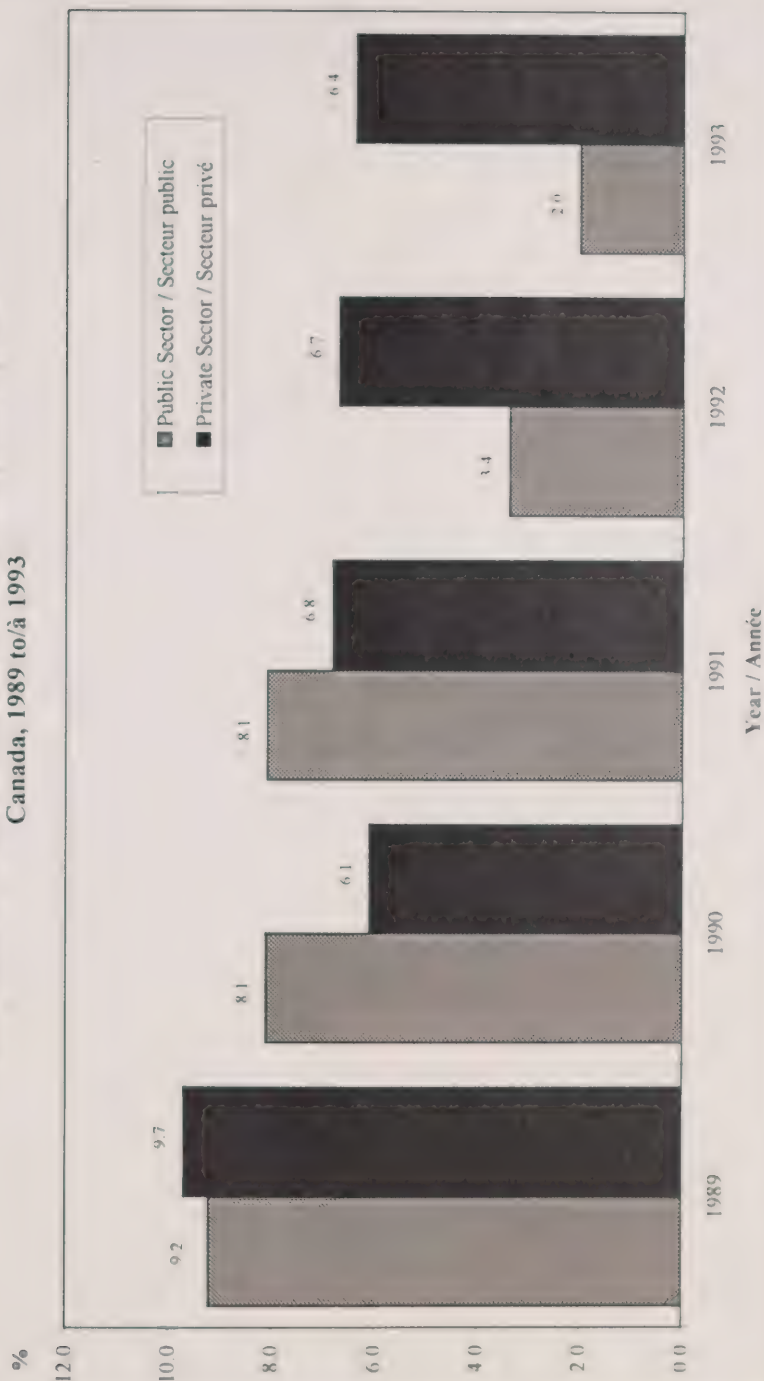
I want to remind the fans of two-tier medicine that we Canadians made a choice about the structure of our health system a generation ago. We know we made the right choice. Canada needs a healthy society and a healthy economy. Medicare contributes to both.

Thank you.

Health Expenditures as a % of Gross Domestic Product, Canada and U.S.A.,
 Dépenses de santé en % du Produit intérieur brut, Canada et États-Unis,
 1960 to/à 1993



**% Change in Public and Private Health Expenditures,
Changement en % des dépenses de santé du secteur public et privé,
Canada, 1989 to/à 1993**



Source: Health Canada / Santé Canada



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Speaking Notes
for the
Minister of Health
The Honourable Diane Marleau

The 48th World Health Assembly
GENEVA, May 2, 1995



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Mr. President, Dr. Nakajima, fellow ministers and delegates, ladies and gentlemen;

It is a device often used by speakers to an Assembly such as this to say the Organization being addressed is at a crossroads. Often that statement is no more than rhetoric. Not this time. In fact, the World Health Organization is at a critical point in its life.

Major reform activities occurring within the Organization and within the United Nations system as a whole, financial constraints in several of the major UN contributors, the need to renew our health-for-all strategy, and the new global geo-political environment, are all creating demands on our Organization. On the one hand, they threaten its capacity to maintain the highest scientific and technical quality of its programs. On the other hand, they provide opportunities to assure our ongoing relevance.

WHO was created to design, adopt and apply joint solutions and methods to collective health problems. And we now have to ask ourselves how we wish WHO to continue to meet our collective needs.

Mr. President, I want to note that Canada is pleased with the work done to date by the Director General in connection with WHO reform to improve program management, to increase administrative effectiveness and to link resources to agreed priorities. As Member States at this Assembly, we also have a critical role to play. Unless we clarify, individually and collectively, what we expect from WHO as a specialized UN agency, the reform process we have initiated simply cannot succeed.

Canada expects WHO to be the international community's primary vehicle for the collective definition of action for health.

In order for it to do so, we believe WHO and its Member States must:

- ◆ define those tasks which can best be performed at the international level;
- ◆ isolate the key roles for WHO vis à vis Member States;
- ◆ identify its unique responsibilities within the UN system during the reform of that system; and
- ◆ adopt a work program which reflects its realistic financial ability to deliver the functions so identified.

We believe that if we accept to do these, new program directions will emerge. Some will include a greater emphasis on disease surveillance and the coordination of disease and prevention programs at the global level. Another will strengthen WHO's basic normative functions in relation to pharmaceuticals, medical devices or other areas of health regulation. And equally important, will be the greatly increased capacity to share health information among Member States.

In addition to the fundamental issue of WHO reform, several priority activities of the Organization are on this year's agenda and we are invited to adopt resolutions that will further global public health. In connection with Tobacco or Health, we will ask the Director-General to investigate the feasibility of developing an International Convention on Tobacco Control. I believe that it is now time for Member States to consider adopting such a global regulatory instrument.

In this connection, last year, the Government of Canada approved a major **Tobacco Demand Reduction Strategy** that combines three areas of activity -- legislation, research and public education. The Strategy also includes an international component which is providing support to WHO's tobacco or health program.

We also have in front of us for consideration a conceptual and strategic framework for reproductive health. This issue is particularly important to Canada and to me as Minister of Health. In the wake of the International Conference on Population and Development, and a few months before the World Conference on Women, it is extremely important for us to define clearly the role and responsibilities of WHO.

Reproductive health is a personal, individual matter, but it is also a collective, social issue of concern to all. WHO proposes to concentrate on the collective, social side of reproductive health through a public health approach. We agree that this utilizes the Organization's comparative advantage. We also believe we must collectively monitor and assess the ethical dimension of new reproductive technologies.

Dr. Nakajima suggested during the meeting of the Executive Board last January that heads of delegations focus on **Equity and Solidarity for Health: Closing the Gap** during their statements in plenary. This suggestion was no doubt motivated by the latest report on *Monitoring of progress in the implementation of strategies for health for all by the year 2000*.

Among the conclusions of the report, we learn that globally, life expectancy continues to increase, and infant and maternal mortality is gradually declining.

Progress is also being recorded in other specific areas, such as polio eradication, and leprosy. However, we are also informed that new and old scourges continue to cause death and suffering among the poor and most vulnerable populations of the world, and that the gap between the haves and the have nots remains as wide as ever. In order to meet this challenge, WHO is currently advocating a health futures approach to help define Member States health needs of tomorrow.

Canada is also prepared to take on this challenge. A few months ago we released a discussion paper entitled *Strategies for Population Health: Investing in the Health of Canadians*. This document provides a framework for action on the major determinants of health. It gives us a solid basis to set priorities to continue to improve the health of Canadians. The paper recommends three strategic directions.

First it recommends strengthening public and government understanding of the determinants of health by demonstrating the links between social status, economic development, income distribution, education and health.

Second, it recommends building understanding and support among government partners in sectors outside health.

And third, it is suggestive of priority initiatives which will have a significant impact on population health.

To that end, we have recognized that Canadians who are economically disadvantaged, unemployed or poorly educated are more likely to suffer from ill health and to have a lower life expectancy. Like governments everywhere, we will strive to deal with these problems.

We are committed to an equitable health care system. The vast majority of Canadians are solidly behind the efforts being made by governments, professional groups and other stakeholders to improve the efficiency of the system.

My government recognizes and affirms these Canadian values at home by preserving a largely publicly-funded, universal, comprehensive, accessible, and portable health care system.

Canada has a long history of commitment to these principles in serving a dispersed population in a federal system of government. We will maintain our commitment to these principles notwithstanding some difficult economic realities that we, as many nations of the world, are experiencing at the moment.

Internationally too, Canada's actions are influenced by policies based on equity and solidarity. Recent policy decisions relative to official development assistance will ensure that at least 25% of our aid programs will be devoted to basic human needs such as health, education, water and sanitation. The rest are devoted to economic development intended to improve general living conditions and, in keeping with what we now know about health determinants, thereby to improve health.

Equity relates not only to income distribution, but also to gender. In this context, I should like to note my government's commitment to improving the health of women. The 4th UN World Conference on Women next Fall in Beijing will draw particular attention to the health needs of women around the world. The specific health concerns of women vary in different parts of the world. But we can say in every country, including my own, that the health status of girls and women is related strongly to their economic, social and cultural circumstances.

The susceptibility of women to ill health because of poverty, the lack of attention to their specific health needs, their vulnerability to diseases such as AIDS and physical violence, are also societal issues of gender inequality.

We know we must take a multidisciplinary approach to women's health. In Canada we are working on a women's health strategy which takes such an approach. We are interested in the major illnesses and diseases which particularly affect women, as exemplified by our work on breast cancer. And we know we must take a gender-specific approach to disease prevention and health promotion.

We have recently announced our support for Centres of Excellence for Women's Health in Canada which will ensure that the past neglect of important issues affecting women is reversed. The Centres will focus on the broad determinants of women's health and on changes in how our health system understands and addresses women's health needs. The health system must regain the confidence of women by providing them with relevant information, and effective and appropriate diagnoses and treatment.

We commend the work of the Global Commission on Women's Health and trust that WHO will place a high priority on the health of girls and women.

In conclusion, let me reaffirm Canada's belief that WHO has an important role to play to further equity and solidarity in health. Documents such as the WORLD HEALTH REPORT 1995 introduced earlier this morning by the Director-General are good examples of the work of WHO in collecting and analyzing data about the world health situation. They document the situations in countries and the differences between countries, and are consistent with our expectations about the role of WHO.

We know, as you do, that there is never enough money or an adequate supply of human resources to deal fully with all the world's pressing health problems.

In a less than perfect world like ours, it is all the more important that we have organizations like this one so that we may focus our collective efforts and do the very best we can with what we have. That is why Canada supports WHO and its reform efforts, and that is why we wish all the best for this Assembly. And let me also reconfirm our commitment to the reform process now underway.

Thank you.



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Speech / Discours

Speaking Notes
for
the Minister of Health
The Honourable Diane Marleau

House of Commons,
Ottawa, April 27, 1995



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Votre référence

Notre référence

As you may be aware, Members of Parliament debated an Opposition Day Motion relating to the health care system on April 27, 1995.

Mr. Preston Manning (Calgary Southwest, Ref.) moved:

That this House recognize that since the inception of our national health care system, the federal share of funding for health care in Canada has fallen from 50 percent to 23 percent and therefore the House urges the Government to consult with the provinces and other stakeholders to determine core services to be completely funded by the federal and provincial governments and non-core services where private insurance and the benefactors of the services might play a supplementary role.

Given the importance of this issue, I thought you would be interested in reading what the Minister of Health, the Honourable Diane Marleau, said during the debate.

Comme vous le savez probablement, les députés ont participé à un débat sur le système de soins de santé, le 27 avril dernier, lors d'une journée réservée aux motions de l'Opposition.

M. Preston Manning (Calgary-Sud-Ouest, Réf.) a proposé:

Que cette Chambre reconnaisse que, depuis la création de notre régime national de soins de santé, la part du financement fourni par le gouvernement fédéral est passée de 50 pour cent à 23 pour cent et, par conséquent, que la Chambre exhorte le gouvernement à consulter les provinces et d'autres intervenants, afin de préciser quels sont les services essentiels qui seront entièrement financés par les gouvernements du Canada et des provinces, et les services non essentiels pour lesquels les assurances privées et les bénéficiaires des services seront peut-être appelés à jouer un rôle complémentaire.

Vu l'importance de la question, j'ai pensé que vous seriez intéressés à prendre connaissance des propos tenus par la ministre de la Santé durant le débat.

Michèle S. Jean

Canada

Madame Speaker,

I would like to thank the leader of the third party for setting forth in his party's motion a proposal which I would qualify as almost perfect, almost perfectly wrong that is. The proposal demonstrates clearly that Reform Party members do not understand how the Canadian Health system functions, what challenges it faces, what is being done to address those challenges, and what solutions are realistic and make sense to Canadians.

In his medicare proposal and in his pronouncements on the Reform Party's views, the leader of the third party has managed to put together a package that will simultaneously increase bureaucracy, decrease flexibility, maximize federal interference in provincial jurisdiction and, most of all, increase the costs of health care in Canada.

And how would the Reform Party pay for this?

It's simple: It would push people into buying private insurance, if it is available and if they have the money for it, to cover things presently covered by medicare. Worst of all, it would tax the sick by permitting and even encouraging user fees.

The Reform Party proposal and pronouncements are not a prescription for a healthy medical system. They are a prescription for disaster.

Before dealing with the specifics of this motion and of Reform's "thinking" on medicare, let me question the proposals of the Reform Party.

Reform's so-called "Budget" proposed surrendering additional tax points to the provinces for health care. How precisely does this square with your concern about a falling federal share of cash contributions? Certainly not well at all.

How would the Reform Party deal with the fact that tax points yield different revenues in each of the provinces? It obviously has not thought of that.

How would that party enforce the conditions and criteria of the Canada Health Act? It certainly appears it would not.

What, if any, evidence do members of the Reform Party have to support their expectations that provinces would agree on a common level of basic or core health services everywhere in Canada as they state they would on page 48 of their so-called budget? Are they not aware that a number of provincial Ministers of Health have already indicated that such an approach is simplistic and that they have no interest in developing a national list?

Which is the federal role? To determine core services, - as the motion states or to have provinces agree on a common level of core services as stated in Reform's so-called taxpayers' budget? How would the leader of the third party coerce the provinces?

The Reform Party obviously has no answers for these questions. That is the reason its arguments have no basis in fact and are almost perfectly wrong. It is a soapbox rhetoric which could lead to the destruction of medicare, and we are not going to have any of it.

Take this motion, for example. In dealing with federal contributions to provincial health insurance plans, the honourable member mixes apples with oranges. He does it all the time, so this is nothing new.

The federal share of funding for health care was never 50 per cent of total provincial government health expenditures. As a result of cost sharing during the 1960s and early 1970s, the federal share nationally accounted for roughly 50 per cent of provincial expenditures for hospital and medical care only. Even then provincial governments were spending on health programs for which the federal government did not share costs.

Let us look at some real numbers, not those fabricated by the Reform Party. In 1975-76, after medicare was introduced, the federal contribution nationally amounted to 39 per cent of total provincial health expenditures. In 1992-93, the federal contributions, the sum of the cash in transfers to the provinces for health represented 32 per cent of total provincial government health expenditures.

Another way to look at the numbers is to examine the federal share of total health expenditures in the country. On this basis, the federal share has dropped from 31 per cent in 1975-1976 to 24 per cent in 1992-1993.

Let me repeat it again, so that, hopefully, Reform members will understand eventually. In dealing with federal contributions to provincial health insurance plans, the Reform Party leader is mixing apples with oranges. The federal share of funding for health care was never 50 per cent of total provincial government health expenditures.

As a result of cost sharing agreements reached during the sixties and the early seventies, the federal share nationally accounted for roughly 50 per cent of provincial expenditures for hospital and medical care only. Even then, the provincial governments were spending on health programs for which the federal government did not share costs.

Let us look at the real figures, not those fabricated by the Reform Party. In 1975-76, after medicare was introduced, the federal contribution nationally amounted to 39 per cent of total provincial health expenditures. In 1992-93, the federal contribution, that is the sum of the cash payments and tax transfers to the provinces for health, represented 32 per cent of provincial government health expenditures.

These are all real numbers and public numbers. They should be the Reform's numbers because they are the facts.

Provinces administer the health care system. I want to make it clear and acknowledge in the House what I have said elsewhere. Provinces and territories are doing a good job of containing costs but historically, the costs of provincial health plans increased in a less controlled manner. It is in part because of this that federal shares of health expenditures have fallen over time. If health costs had risen at the average rate of OECD countries, the federal share would be substantially higher.

Expenditures in the public sector are being controlled. Our cost control problems are now in the private sector. Pray tell, why would we shift more to the private sector so we can have even higher and less control of costs?

In 1993, Canada spent 72 billion dollars on health care. This represented 10 per cent of our Gross Domestic Product. Honourable members are aware that with the exception of the United States Canada's health expenditures are the highest of any industrialized nation.

There is enough money in the system. It is a question of how better to spend the money we have. Of the 72 billion dollars spent in 1993 approximately 52 billion dollars was spent in support of public health services while the other 20 billion dollars was spent in the private health sector. Lately, the public component has been growing at less than 2 per cent. On the other hand private health spending has been growing by more than three times that rate.

The public sector, or single payer system, has enabled the provinces and territories to better control the rate of increase in the growth of health expenditures in the public sector. The World Bank's 1993 World Development Report noted the cost effectiveness and control advantages of public sector involvement in health: "In general, the OECD countries that have contained costs better have greater government control of health spending and a larger public sector share of total expenditures."

The OECD review of health reform and development in Canada, also recognized the advantage of a significant public sector involvement in health. From the 1993 OECD Economic Survey of Canada: "The structure of Canada's single payer health system lends itself to effective supply management and control. It seems that the problems of the current system are not related to its publicness."

With respect to health expenditures for 1994, preliminary estimates by my officials indicate that public health expenditures declined in aggregate by about 1 percent in 1994 while private expenditures increased at about the same rate as in 1993. Under these assumptions, total health expenditures in 1994 were approximately 73 billion dollars, for an aggregate increase of less than 1 percent, or about 600 million dollars. Expressed as a percent of GDP, total health spending probably declined to about 9.7 percent in 1994.

There are a number of reasons why we have been more successful in controlling health costs in the public sector than in the private.

We have in each province a structure which provides the same coverage to everyone. It is not necessary, therefore, to assess individual risks. Payments to providers are made in a simple but efficient manner. Financing of the system is simple; everything possible is done to reduce costs. In fact, researchers from Harvard University found that Canada only spends 1.1 per cent of its gross national product on health care management.

If we spent as much as the United States do on that, health care expenditures would increase by 18.5 billion dollars. Americans spend almost two and one half times as much as we do on that. And there is no evidence that spending more would improve the health of Canadians.

The second reason we are in a better position to control costs is that there is only one purchaser in our provincial health insurance plans. Governments have great clout when it comes to negotiating the level of costs of services. They can set overall budgets for hospital and physician services. In fact, they have done so, as indicated by the figures I quoted.

As Minister of Health, I want Canadians to continue to have access to high quality health care at a price we can afford. That is why I am working with my provincial and territorial colleagues, as well as other stakeholders, to address cost drivers in both the public and private health sectors -- so much for the first part of Reform's motion.

Let me now deal with the second part which calls for a listing of core services. There is a remarkable degree of congruence between provinces. Among them there is broad agreement as to what constitutes the core of ensured physician and hospital services. There are some differences from province to province but these simply demonstrate the flexibility which provinces can and do exercise in providing a range of additional benefits to their residents. That is not wrong. That is a strength of our system; a system characterized by sound consensus on what are core services or medically necessary services.

The list of covered procedures and services of necessity must be flexible. That is because the way we deliver health care and the opportunities which new technologies and procedures create dictate changes need to be incorporated over time. There is almost no service not medically appropriate in some cases.

For example, plastic surgery may be considered medically necessary when it is intended to correct a medical condition. Reconstructing a nose to correct a breathing problem is labeled as cosmetic surgery but, clearly, it is a medically necessary surgery.

Other examples include removal of minor skin lesions when cancer is suspected, and tattoo removal in the case of abuse or prisoner-of-war experiences.

For the most part in Canada, we have left the definition of medical necessity to professionals, not to bureaucrats. The medical necessity of a service is determined at the point of delivery of the service. That is what the Canada Health Act has allowed. It is based on the medical needs of the patient, not the financial means of the consumer. That is the way it should be; this is simple fairness.

Canadians do not want cash register medicare. This stands in sharp contrast to what is happening with managed care in the United States. There, third party insurers tell physicians what they cover and what they can or cannot do for their patients. So much for clinical freedom.

This reality is one of the major reason why a significant proportion of doctors who leave Canada to practice in the United States come back home.

The Reform Party says it stands for smaller government, less bureaucracy. Therefore, I find it strange that they are suggesting a process that would increase bureaucracy. And let there be no doubt, producing the list of medically necessary, or core services would involve more bureaucracy.

Medical necessity is an integral part of the understanding and operation of the *Canada Health Act*. It is at the very heart of the principle of comprehensiveness.

In the *Canada Health Act*, the words medically necessary are used in conjunction with other conditions. This ensures that once a service has been determined to be medically necessary and insured by provincial health insurance plans, it is accessible in uniform terms and conditions by all residents of the province, and available to them when they travel across the country.

In a manner of speaking these become rights of Canadians. These are rights that the *Canada Health Act* is there to protect. Canadians expect that they will have medically necessary services available without point of service charges. They are right in this expectation. This is why facility fees for medically necessary services in private clinics are unacceptable, and why I took steps to address this problem in January.

A rigid list of medically necessary services encourages the development of a second tier of health care delivery. It promotes privatization and shifting the burden of costs from society to individuals. These costs would then be borne by patients or by their employers.

Reformers who professes to know what is good for business, should ask business people what they think about this idea. Let them talk to the owners of small businesses, the independent entrepreneurs who account for so much economic growth in our country, who have tried to buy insurance to cover the health cost of their employees. They know how costly it is already, and they appreciate how much more expensive it would be if they had to cover more services and medically necessary services as well.

I ask Reform Party members, in particular, the member from MacLeod, who is a physician, to tell us which services they think are not medically necessary, which services they think should be deinsured and which services he thinks individual patients should pay for.

Even the Premier of Alberta is unable to provide a list of what these should be. The government's agenda is a national one. It is aimed at doing what is necessary to renew our health system to make it more efficient and effective. It is an agenda based on better health outcomes, not better incomes.

The motion before us urges me to consult with the provinces. Since becoming Minister of Health, I have made it clear that I want to work with the provinces and territories and I have. I have met with my provincial colleagues. I talk to them on a frequent basis. We have arrived at a consensus about the need to support the principles of the *Canada Health Act*.

I am prepared to continue this collaboration. Our next regular meeting is scheduled for September, but I have already told the provinces that I am ready to meet them earlier. There is no lack of willingness by this government and this Minister -- to work with the provinces, territories and others to ensure that Canadians continue to have the best health care system in the world.



Speech / Discours

Speaking Notes
for the
Honourable Diane Marleau
Minister of Health



Announcement of Funding for
Six Permanent Solvent Abuse Treatment Centres
for First Nations and Inuit

House of Commons, Centre Block
Ottawa, May 11, 1995

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Ladies and gentlemen, the dilemma of solvent abuse has devastated many First Nation and Inuit communities. It has ended too many lives too soon. Action must be taken now if we are to assist a generation of Aboriginal youth in dealing with this problem.

Today, I am pleased to announce the establishment of six new permanent solvent abuse treatment centres for First Nations and Inuit people across Canada. Five of these centres will provide the standard six-month treatment program for solvent abuse, while the sixth will provide long-term treatment to First Nations and Inuit people who are unable to attend a standard treatment program.

These six centres were selected from among 24 proposals received by my department after we issued a call for proposals in March 1994. Our original plan was to fund three centres, but the quality of the proposals, and the severity of the problem, compelled the special Solvent Abuse Selection Committee to recommend six centres. I have accepted this recommendation.

With the establishment of these treatment centres, a full range of solvent abuse services is available to First Nations and Inuit people. Health Canada is supporting the complete continuum of care, including solvent abuse prevention and intervention, treatment, training and pre- and post-treatment services.

My department will spend \$7.2 million annually in supporting these six centres. These funds, which will support approximately 90 new beds, will be secured through a combination of new funding and a reallocation of existing departmental resources.

The five standard treatment centres that will be funded under this program are:

- ◆ the **Nenqayni Treatment Society Centre** near Williams Lake in northern British Columbia.
- ◆ the **Prince Albert Grand Council** treatment centre in northern Saskatchewan.
- ◆ the **Manitoba Keewatinowi Okimakanak Inc.** treatment centre in northern Manitoba.
- ◆ the **Southern First Nations** treatment centre in southern Ontario.
- ◆ and the **Ka'Uauitshiakanit** in southern Quebec.

The sixth centre I am announcing today was proposed by the **Nishnawbe-Aske Nation** of northern Ontario, and will provide a unique treatment service. This facility will focus on the long-term, with the objective of preparing chronic solvent abuse patients to attend a standard treatment program.

Today's announcement is a critical development in solvent abuse treatment for First Nations and Inuit people. With these six new centres, we have more than tripled the funding and the number of beds available specifically for First Nations and Inuit solvent abuse treatment.

As you may know, my department's Medical Services Branch is already supporting 43 beds at the Sagkeeng Solvent Abuse Treatment Centre at Fort Alexander, Manitoba. This centre will continue to receive up to \$3.3 million in funding each year.

The funding for these new centres supplements the Government's budget for solvent abuse under the **Building Healthy Communities** strategy, which I unveiled last September.

Building Healthy Communities is a five-year, \$243 million dollar strategy which strengthens and expands existing health programs for First Nations and Inuit people in areas of critical need. It is a concrete example of the collaborative approach to addressing health problems that was called for in the Red Book.

Over the next five years, the **Solvent Abuse Program** of the **Building Healthy Communities** strategy will provide a total of \$62.4 million in new and existing funding to address this health challenge, which is essentially a problem of young people. These programs will enable my department to establish a fuller range of initiatives than have previously been available, in cooperation with First Nation and Inuit communities.

Before accepting questions, I would like to acknowledge the work of the Solvent Abuse Selection Committee, which was comprised largely of First Nations and Inuit representatives. The committee had a difficult challenge in sorting through the many worthy proposals, and I fully endorse their selections. I would like to thank the six individuals involved -- namely Patrick Dumont, Phil Fontaine, Dell Graff, Rosie Kagak, Larry Whiteduck and Margaret Clark -- for their hard work and dedication.

The process that was used to select these treatment centres is an excellent example of how government can work in partnership with First Nations and Inuit peoples to find effective, practical solutions to our shared objective of building healthier communities.

These new centres are an important step forward in providing Aboriginal communities with the resources they need to tackle the serious and urgent problem of solvent abuse which, as I said a moment ago, has already claimed the lives of too many First Nations and Inuit youth. I am looking forward to moving quickly to the next phase of this initiative, so that the treatment centres can become operational and begin to have an impact as soon as possible.

Thank you.



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**Speaking Notes
for
The Honourable Diane Marleau
Minister of Health**

**At the presentation of
The Main Estimates
for the year 1995-1996
Ottawa, May 18, 1995**



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Canada

I am pleased to appear before your committee, once again, to discuss my department's Main Estimates. As a former Associate Finance Critic and Chair of the Finance Committee of the Regional Municipality of Sudbury, I have always supported careful scrutiny of public spending. Canadians demand that we spend their tax dollars wisely.

This morning I will review what I have concentrated on since my appointment and outline my priorities for the coming year. I will then be glad to answer all your questions.

The more I consider my responsibilities as Health Minister, the more I realize they are about providing a sense of security to Canadians. At a time when so much is changing in Canada and in the world, people need security to cope with change. They expect their governments to play an important role in that regard. I do not mean this in a paternalistic sense. I strongly believe in individual responsibility. But only government can provide the benefits of universal health insurance, ensure the safety of drugs, and invest the hundreds of millions of dollars required for health research.

Other members of Cabinet play a key role in providing Canadians with a sense of security. As members of the Standing Committee on Health, you understand the special role of Health Canada. Safe streets are a vital part of personal security but, day-to-day, safe food, safe water, safe drugs and knowing that you will be looked after if you fall ill, regardless of your income, are perhaps even more important.

Let me now turn to what we have accomplished. I will not review the Red Book's health commitments in detail this morning. But I want to tell you that I am proud of these programs. I am particularly proud of the two devoted to the health of children, **Aboriginal Head Start** and **Pre-Natal Nutrition**. Having heard from Fraser Mustard, you no doubt have a full appreciation of current scientific thinking on the importance of a healthy childhood particularly from birth through the pre-school years.

I understand the members of the **National Forum on Health** have also appeared before this committee. The outstanding Canadians we have appointed to the Forum have taken their work very seriously and are now in a position to offer advice. They are concentrating on four main themes: determinants of health; evidence-based decision making; values; and striking a balance. The latter theme is concerned with the need to use our limited resources in a balanced way to achieve the best outcomes.

At their meeting on March 15 and 16, Forum members confirmed their support for the principles of the *Canada Health Act*, and for public funding of the health system. The Forum now has approximately 50 projects under way, and it will begin a process of public dialogue in the fall of this year.

The fourth Red Book commitment I have met is the launching of **Centres of Excellence for Women's Health**. After seeking the views of hundreds of women across the country, we are preparing to invite interested groups to submit their intent to bid by the end of May. As well, I am pleased to say that I am exploring the possibility of a joint conference on women's health with U.S. Secretary of Health and Human Services, Donna Shalala.

In addition to these specific initiatives, I have been fully engaged in the defense of medicare. I invite you to think about what we have accomplished. Forget the rhetoric. Look at the facts. Last September, at a meeting in Halifax, all Health Ministers agreed to work cooperatively to uphold the principles of the *Canada Health Act*. This kind of federal-provincial entente should be underlined.

Also in Halifax, all ministers present, except the Alberta minister, agreed on the need to regulate private clinics. As a result, on January 6, I sent the provinces an interpretation letter on the *Canada Health Act*. I asked them to eliminate situations where private clinics offer medically necessary services and charge patients a facility fee. I will return to this in a moment.

During this period, I have also shown that I will use the powers of the law when appropriate. In May 1994, almost a year ago today, we began deducting \$1.7 million from transfer payments to British Columbia in order to discourage extra-billing. The *Canada Health Act* provides for dollar for dollar deductions for those provinces who allow physicians to charge extra for medically necessary services.

We have grappled with many other tough issues. The committee is familiar with the Tobacco Demand Reduction Strategy developed as part of the government's anti-smuggling action plan. More on this later, but I want to tell you how much I appreciate your support on what continues to be a difficult file. You will be pleased to hear that, last week, the annual meeting of the World Health Organization adopted a resolution we had co-sponsored that calls for the development of an International Convention on Tobacco Control.

It is hard to find a role more central to the security of Canadians than the safety of our blood supply. Of course, we are awaiting Justice Krever's final report on this matter. In the meantime, I have taken action to reinforce ongoing regulatory procedures and practices within Health Canada related to blood and blood safety.

One of the most sensitive issues we face concerns new reproductive technologies. Having discussed this with the ministers of health of several countries, particularly Mme Simone Veil, I know that this is one of the toughest issues with which we must deal. I have consulted with my provincial colleagues as well, and I expect to announce interim measures in the near future.

I have said, since taking office, that breast cancer would become one of my Department's priorities. Following the extremely successful National Breast Cancer Forum, in partnership with the Medical Research Council and the National Cancer Institute of Canada, we have funded over 24 projects for \$6.8 million to study issues like prevention, treatment and supportive care for breast cancer.

It is often forgotten that two-thirds of the budget of my department, excluding transfers to provinces, is devoted to native health. At a time when most government programs are being cut back, I have been able to secure continued growth in funding for this sector, as announced in the last budget. I have invited the leaders of the First Nations to work with my department in identifying ways of achieving the lower targets it provided. And I announced just last week the establishment of six permanent treatment centres to combat solvent abuse in aboriginal communities.

However, our major focus is, and will continue to be, the transfer of control of programs to First Nations themselves. Along with many other initiatives, I think these illustrate our government's commitment to redressing what are really inexcusable health inequalities.

I will not enumerate the many important health promotion activities of my Department, but I do want to highlight our work on AIDS, family violence, and our assistance to vulnerable seniors.

Defining, assessing and managing current and emerging health risks are among the responsibilities of the Health Protection Branch of Health Canada. This branch plays a unique role in ensuring the safety of the country's food, drugs, cosmetics, medical devices and consumer products and sustaining the country's health protection infrastructure.

Canadians look to Health Canada for reassurance whenever there are natural or civilian disasters or threats to national health from chronic diseases, such as cancer and tuberculosis, or communicable diseases such as AIDS/HIV or the Ebola virus. To track and understand threats to the health of Canadians, we are strengthening our health intelligence network to share data and research with our provincial and territorial colleagues and enable us to make cost-effective choices regarding risk management and the use of new technology.

Here, I want to say a few words about management, a topic we ignore too often. When I assumed this portfolio, I advised my officials that value for money is one of my main objectives. I deeply believe in the mission of Health Canada, but I want it carried out without frills. I am prepared to spend more money when I think it is called for, as I believe it is in the fight against breast cancer. But I have no time for waste. I asked the department to review its spending in a number of areas such as common services and laboratory operations. By streamlining the management of common services such as financial management, assets and informatics we expect to save up to \$6 million. Consolidating our laboratory operations is expected to generate \$8 million in savings by 1997-98. This is what I mean about spending smarter.

With a personal priority of that nature, you will understand why I welcomed Program Review. In recognition of the importance of health, our cuts were not as deep as in many other departments. But we took advantage of Program Review to carry out significant internal reallocations in order to fund new priorities, such as the improvement of our health surveillance capability.

We also decided to focus the work of the department on four business lines:

- ◆ Health System Support and Renewal
- ◆ Population Health Strategies for Groups at Risk
- ◆ Delivery of Services to First Nations, Inuit and Yukon
- ◆ Management of Risks to the Health of Canadians -- Products and Disease Control

I want to take this occasion to underline the dedication of my officials. They do an enormous amount of work to serve Canadians and I thank them for that.

Let me turn now to my priorities for the next year. I see a great deal of continuity, and I also expect some new undertakings.

First, I will continue to defend the principles of medicare. Canadians have a strong attachment to their health system and the federal role in it. They look to the federal government to provide a viable, well-managed, national health care system. In fact, according to an Angus Reid poll of March 1995, almost all Canadians want national standards in health care, with 94 percent saying such standards are somewhat or very essential.

In view of the need for fiscal restraint, this will continue to be a challenge. I remain convinced of two things:

- ◆ the principles of medicare are as valid as ever, and
- ◆ it is the alternative to medicare -- two-tier medicine -- that we cannot afford as a country.

Our medicare system, supported by federal and provincial funding, covers 72 percent of total health spending in Canada. This gives us a much greater ability to control costs than the U.S. system. Twenty years ago, Canada and the United States had similar health insurance systems and had similar rates of health spending, approximately 7.5 percent of GDP. Last year, the U.S. spent more than 14 percent of GDP on health care and we spent 9.7 percent. What does that tell us?

First, our publicly administered system has enormous economies of scale and much lower overhead costs. Second, since there is only one major buyer in our provincial insurance schemes, governments can use that purchasing power to negotiate lower costs. The private sector does not have the same ability to control health care costs and, as a result, private spending continues to grow at a rate of 6 percent per year. Meanwhile, since 1992, public sector costs have been declining. Compared with U.S. levels on health spending, our national health care system saves the economy \$30 billion a year. The economic argument against privatizing the health system is irrefutable.

This is how I see the next steps with respect to medicare:

- ◆ I have invited my provincial and territorial counterparts to meet with me in Ottawa in late June following their recent Vancouver meeting. We will continue our discussions on the *Canada Health Act* and on health system renewal.

- ◆ In parallel, there are discussions among officials to review progress on the follow-up to my January letter to provinces on private clinics and facility fees.
- ◆ On October 15, in the case of those provinces which continue to allow facility fees, I will start the enforcement process provided for in the *Canada Health Act*.
- ◆ Throughout this period, I will continue to work with my provincial counterparts on initiatives designed to bring health costs down.
- ◆ I am particularly interested in bringing down the cost of drugs, which is the fastest growing component of health spending in this country.

Along with medicare, my highest priority will be continued attention to health protection. I am talking about protecting Canadians against risks to their health arising out of emerging diseases, out of dangerous products, out of the environment, out of unsafe drugs. We are going to put much of our activities in this sector on a cost recovery basis. This will provide us with the resources to do the job Canadians expect, and will offer industry the service it requires.

Regulating products is essential of course, but health protection also requires that we have in place surveillance systems that allow us and the provinces to anticipate problems and find timely solutions. The February budget announced that Health Canada would be reinvesting any savings from planned expenditures in areas where we can exercise federal leadership, such as public health intelligence networks. This will include better international networks, through the World Health Organization and the Centers for Disease Control and Prevention in Atlanta for example.

Thanks to our current efforts in this area, we are able to be up-to-date on events in Zaire concerning the Ebola virus. Let me say this morning that the risk to the health of Canadians is extremely low, but we have in place the measures that will allow us to react very quickly should any threat emerge.

I would just like to say a few words on generic packaging, one of the measures outlined in the Tobacco Demand Reduction Strategy. You are all familiar with this issue, having produced a very useful report entitled *Towards Zero Consumption*. You will recall that Health Canada commissioned an independent Expert Panel to consider the impact of plain and generic packaging on the uptake and cessation of smoking. The panel did an incredible amount of work and submitted their report to me at the end of March. I will make this report public tomorrow.

Building on what we have already put in place, I have asked my department to place a high priority on women's health. We already have a significant number of activities and initiatives that bear directly or indirectly on the health of women. I want to ensure that they are well coordinated and that they add up to a comprehensive approach. We will be greatly assisted in this by the Centres of Excellence, which I hope will be starting their work in early 1996.

As the committee knows, my department administers many programs for vulnerable groups. Over the years, they have grown in response to well-defined needs. During Program Review we decided that with limited resources available, and the need to avoid duplicating provincial programs, we have to ensure that our programs are based on the best information available on the health status of Canadians and on a strong sense of priorities. The intent is to have population health strategies that build on twenty years of innovative work in this department, and that evolve as the needs of Canadians evolve.

Finally, I place a high priority on research. It is not well known that the federal government spends about \$340 million on health research annually. Altogether, we estimate that in Canada we spend about \$1.5 billion a year on health research. An enormous amount of good work gets done by a lot of people. It is clear, however, that there is much that we do not know -- about the efficacy of many medical procedures, for example.

At my request, in cooperation with other interested departments and agencies, including Health Canada's own National Health Research Development Program and the Medical Research Council, the Department is currently looking at the health research effort at the federal level. We want to see how research -- both applied and biomedical -- can help us achieve value for money in health care. In addition, we are working closely with provincial governments to see how we can do the same thing at the provincial level.

In conclusion, Mr. Chairman, let me return to my main theme -- providing Canadians with a sense of security. We provide them with a sense of security when they know they will be taken care of if they are sick, when they know the products and drugs they use are safe, when they see the measures we take to prevent disease. This is what we must do to earn the trust and confidence of Canadians. We will strive to do our work with excellence and integrity.

Mr. Chairman, I would be happy to answer questions from members of the committee.



Speech / Discours

Speaking Notes
for the
Honourable Diane Marleau
Minister of Health



Third Annual International Conference on
Diabetes and Indigenous Peoples
Winnipeg, May 28, 1995

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27/95

Honourable guests, ladies and gentlemen, good morning. On behalf of the Government of Canada, I am pleased to be here at the Third International Conference on Diabetes and Indigenous Peoples.

I am delighted that my department is the major sponsor of this important conference. We are all aware that diabetes is a serious and growing health problem for Aboriginal people around the world, and this annual symposium brings together many dedicated individuals and organizations to focus research, learning and decision making on alleviating this health burden.

I am particularly pleased to see an emphasis in the conference program on traditional healing methods and community-based approaches to preventing and treating diabetes. In recent years, my department has been re-focusing its efforts to provide for greater Aboriginal involvement in designing and delivering health care programs at the regional and community level.

There is a critical role for traditional Aboriginal practices in the healing process. In Canada, we know we can learn a great deal from First Nations and Inuit people, and we know we can learn from Indigenous people in other countries. By bringing together delegates from different nations, this conference will foster the sharing of ideas and approaches from many parts of the world.

Diabetes is one of the most serious chronic diseases among Aboriginal populations in Canada. Over the past 40 years, non-insulin-dependent diabetes mellitus has increased at an alarming rate in the First Nations population. In western Canada, the non-insulin-dependent variety has become the most common chronic health condition reported by nurses working on First Nation reserves.

Diabetes rates among Aboriginal people are from two to five times greater than for Canadians in general. Of particular concern is the appearance of non-insulin-dependent diabetes mellitus in children as young as seven years old. This is an extremely rare condition among non-Aboriginal children in Canada.

Over the past decade, my department has worked in partnership with a variety of Aboriginal groups and other stakeholders to improve knowledge, awareness and treatment of diabetes among Aboriginal people.

For example, for the past several years we have provided funding to the **Assembly of First Nations** -- another sponsor of this conference -- and the **Union of New Brunswick Indians** to hire Diabetes Coordinators. We have also undertaken cooperative projects with the **Canadian Diabetes Association**, which again is a driving force behind this international conference.

Working with these and other partners, my department produces educational materials, sponsors educational events and supports research on diabetes in the Aboriginal population. In fact, some of the papers that will be presented at this conference are based on research supported by Health Canada. We also support awareness initiatives, such as videos and newsletters, and the training of professional and lay people in the prevention and treatment of diabetes.

As Minister of Health, I am well aware of the serious health problems facing Aboriginal people in Canada. However, I am convinced that by working together, we can begin to address these problems. As a further example in the area of diabetes, I point to the work of the Nutrition Committee in Southern Ontario. It has worked with First Nations in Ontario and the Canadian Diabetes Association to produce culturally-sensitive material that emphasizes the need for individual responsibility and adopting a healthy lifestyle in dealing with this serious disease.

In order to assist Aboriginal peoples in Canada to improve their health status, the Government of Canada is committed to building a new partnership that is based on trust, mutual respect and participation in decision-making.

The theme of this conference, with its emphasis on hope, is particularly appropriate for the Indigenous peoples, especially here in Canada. That is because Aboriginal people are increasingly recognizing the importance of implementing their own solutions to serious health problems like diabetes. As you continue to take charge of your own lives, I believe you have every reason to be optimistic for the future.

I am hopeful and optimistic that this conference will shed some new light on the problem of diabetes in Indigenous populations. I would like to thank Linda Brazeau and Brenda Thomas for inviting me to join you today, and I wish you success in your work.

Thank you.



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Speech / Discours

Speaking Notes
for
the Minister of Health
The Honourable Diane Marleau

Program Announcement
for the
Aboriginal Head Start Initiative
Grandview Elementary School
Vancouver, May 29, 1995

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29/95

Ladies and gentlemen, boys and girls, thank you for joining us today.

I am delighted to be in Vancouver, and especially happy to be with so many young people. Thank you very much for welcoming me to your school, Grandview Elementary School.

I am pleased to formally announce that the federal government is meeting another commitment we made to Canadians in the Red Book. It is a commitment that invests in the health and well-being of Canada's Aboriginal children.

Aboriginal people have told us that there is a need for programs for young children and families that reflect the culture and experience of their communities. Together with Canada's Aboriginal community, we are about to embark on a mission that will support that need.

We can all be proud of the program I am announcing today. It is unlike many programs because we have designed this program together. The program's design was developed with input from Aboriginal people in urban and Northern communities across the country.

Aboriginal Head Start represents a "made-in-Canada" approach that can begin to address the unique needs of First Nations, Metis and Inuit preschool children and their families. We need this because there is ample evidence of the health and educational differences that exist between Indian, Inuit and Metis people, compared with other Canadians, and because we know that, by working together, we can better deal with these problems.

Over half of Canada's Aboriginal population does not live on reserves. And this population is very young: while 7% of Canada's total population is under four years of age, 13% of the Aboriginal population is under four, nearly twice as high.

Studies of Head Start-like programs have proven that investing in young children is one of the best investments society can make. Head Start programs for young children can have profound and positive long-term effects in children's lives.

The Elders tell us that every child has his or her own gift, and it is the responsibility of the community to identify that gift, nurture it and ensure that each child is aware of how special he or she is; that he or she is a gift from the Creator. This traditional belief is a natural starting point for a healthy beginning in life.

Aboriginal Head Start is similar to a community-based early intervention program developed in the United States more than thirty years ago. In the United States, the support for Head Start remains very strong and the programs remain vibrant. American Head Start has led to significant improvements in American children's health, education, self-esteem, and in helping them to meet the challenges along the road to becoming adults.

Those of you who are familiar with American Head Start will be pleased to know that while we will build on their many successes, we hope to improve on what they have done.

An important recommendation from our talks with Aboriginal people was to make the program flexible. Doing so allows the uniqueness of First Nations, Metis and Inuit communities to be respected.

Aboriginal Head Start will not be complicated, and will have little red tape. It will focus on local non-profit organizations, controlled and administered by Aboriginal people, that see the parent as the natural advocate of the child.

Grandparents and Elders will play a significant role in Aboriginal Head Start projects. Young Aboriginal children will benefit from their wisdom and knowledge of traditions.

All Aboriginal Head Start projects will have strong parental involvement. It was recommended to us that parents play a key role in the planning, development, implementation and evaluation of this Initiative.

Aboriginal Head Start will be guided in each region by a committee comprised of Aboriginal people who have been nominated by their peers and bring with them an appreciation and understanding of Aboriginal cultures, values, traditions, experience and educational expertise. They will assist in identifying priority sites and selecting projects.

As well, a National Aboriginal Head Start Committee is being established to ensure the Initiative has support and strength all across Canada. Its members will be chosen because they have a broad understanding of all areas of early childhood development.

It is clear to the federal government that programs for Aboriginal people designed and delivered by them are more successful than those delivered by outside agencies. I have no doubt Aboriginal Head Start committees and local Head Start projects will succeed.

We have placed our investment and trust at the community level because, like you, we believe one of the ultimate goals of this Initiative is to help parents and children build better futures for themselves.

The Government of Canada will continue to work in a strong partnership with Indian, Inuit and Metis people in fulfilling commitments made in the Red Book. Through Aboriginal Head Start, we are continuing to promote community action and empower communities by providing the tools and resources to improve overall economic and social opportunities for children and their families.

Thank you.



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Speaking Notes
for
The Honourable Diane Marleau
Minister of Health

Child Health 2000
2nd World Congress and Exposition
Vancouver, May 30, 1995



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Canada

Good morning and welcome to Vancouver. I bring warm greetings from our Prime Minister, the Right Honourable Jean Chrétien, and echo his wishes for an enjoyable and productive Congress.

Child Health 2000 is an important event for everyone working on behalf of the world's children. It's a unique opportunity to share information on what works best for children and youth, and to focus our attention on common goals.

This second Child Health 2000 Congress builds on the momentum of our first congress three years ago. Your presence here indicates how effective our global partnership for children and youth has become. Our work on behalf of children today will help to determine the kind of world these children will create thirty or forty years from now.

Each year, some 145 million children are born into the world. By the year 2000, one of our partnership goals is to immunize at least 90 percent of children under one year of age against diseases preventable by vaccine. Our present immunization rate is approximately 80 percent world wide. Here, we have made progress. Our global immunization program -- which began in its current form in 1974 -- is one of the most significant preventive medicine initiatives ever undertaken. It has resulted in 1.3 million fewer child deaths in 1993 than in 1985. This represents a 35 percent reduction in the number of deaths.

Regrettably, this is not enough -- close to 2.4 million deaths among children under five years of age in 1993 were due to diseases preventable by vaccine. And there are worrying signs that our successes in immunization are being eroded by adverse social and economic conditions in many developing countries.

I use the example of immunization because its successes and frustrations demonstrate something important we've learned about health issues over the past two decades. We have learned that our progress is very much affected by social, economic and environmental factors not immediately associated with health care. Income and social status, social support networks, education, employment and working conditions and physical environments all play a role. These factors must be worked into our strategies if we are to really affect health outcomes.

The broad determinants of health are important because they provide a solid framework for acting on national and global health issues. As we approach the year 2000, I believe this model will be the key to effective, long-term action on health issues affecting children.

As I speak about health determinants and the need for a population health approach you will be thinking about population groups in your own countries. Here in Canada, there are 6.5 million young people the vast majority of whom are healthy. But Canadians have no reason to be complacent.

Consider the Aboriginal children of Canada. Aboriginal peoples are among the most socially and economically disadvantaged in our country. Their health problems and those of their children exceed Canadian averages in most areas. Although there has been much improvement in recent years, infant death rates and death rates from injuries and suicides remain higher among Aboriginal peoples than the national average.

In Canada there are also children who are at risk because they experience neglect or abuse and poor living conditions. Other groups include youth who are having difficulty making the transition to adulthood. A number of them experience depression, abuse alcohol and drugs, or even turn to crime.

By focusing on health determinants, we are developing national health strategies to improve all aspects of children's physical and mental health.

One of our most effective strategies is the Community Action Program for Children, which addresses the need for healthy child development. This program funds community groups to establish and deliver services to meet the health and developmental needs of at-risk children ages zero to six years of age.

It enables our federal, provincial and territorial governments to work together with community groups across Canada in addressing children's health and social well-being. This kind of collaboration increases the efficiency of program delivery, reduces duplication of services, and ensures the best return on our investment in the health of children and youth.

Canada's federal government has been consulting with communities across our nation to establish national goals for the healthy development of Canada's children and youth. These goals are:

- ◆ to enhance the involvement of children and youth in maintaining and improving their own health;
- ◆ to ensure that all children in Canada have access to the necessary living conditions required for optimal health and growth;

- ◆ to promote healthy behaviours and reduce the incidence of preventable death, disability, injury and illness;
- ◆ to foster strong and supportive families, caregivers and communities;
- ◆ to ensure a safe, sustainable, physical environment for all children and youth; and
- ◆ to develop an intersectoral and coordinated approach to improving health outcomes for children and youth.

The goals emphasize that all levels of government, communities, families and individual Canadians share the responsibility for the well-being of children and youth.

I'd also like to highlight two of the Canadian government's most recent population health strategies which are designed to improve child development.

The first, the **Canada Prenatal Nutrition Program**, is aimed at improving the health of pregnant women whose babies are at risk. Food supplementation is a key element, accompanied by nutrition counselling, support and education. Counselling on lifestyle issues, such as smoking, substance and alcohol abuse, is also provided.

The second strategy -- which I had the privilege to launch here in Vancouver yesterday -- is the **Aboriginal Head Start Program**. This program is designed to help Aboriginal children in urban centres and large northern communities get off to a better start in life. **Aboriginal Head Start** provides early interventions for pre-school children and their families to help overcome the debilitating effects of economic disadvantage and social marginalization. It empowers Aboriginal communities to improve their overall health by helping children and parents work toward long-term health goals and healthy lifestyles.

Many of our health strategies are directed at influencing youth to adopt healthy behaviours and lifestyles. One of our most effective health promotion strategies centres on tobacco use -- our single most preventable health problem. This strategy takes a comprehensive approach to teen smoking, including legislation, research and public awareness.

Canada's commitment to reducing conditions of risk and disadvantage extends beyond our national borders. We are a major contributor to UNICEF through the Canadian International Development Agency. My own Department works closely with the World Health Organization and the Pan- American Health Organization, whose maternal and child health programs provide advice and assistance to countries developing programs to improve child health. Canada contributes over 50 million dollars annually to these organizations.

As part of our commitment to global immunization, Canada, through the Canadian Public Health Association, supports immunization programs throughout the world. Last September, I participated in the ceremonies marking the eradication of the polio virus from this hemisphere -- a truly remarkable achievement. This achievement would not have been realized had countries in the region not made it a priority.

In addition, Canada's Official Development Assistance Program works in many countries to address the effects of poor living conditions on children. It does this in many ways, including:

- ◆ policies and programs to alleviate poverty,
- ◆ programs to provide basic shelter and housing,
- ◆ the provision of temporary housing, water and sanitation to victims of conflict and natural disasters, and
- ◆ urban development activities to improve the quality of life.

As we learn more about the broad determinants of health and develop effective population health strategies for children and youth, domestic and international collaboration will assume greater importance. Collaboration is the key to sharing valuable information and resources on what works best.

As we approach the year 2000, all countries face challenges that only broad social awareness and action can address. I trust that your discussions over the next five days will continue to strengthen our global partnership to create a healthier future for all of our children.

Thank you.



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Speaking Notes
for
The Honourable Diane Marleau
Minister of Health

Announcement of a Nation-Wide Alzheimer
Wandering Persons Registry
Ottawa, June 1, 1995



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Canada

I am very pleased to be here today, along with my colleague, The Honourable Herb Gray, Solicitor General of Canada, and Mr. Stephen Rudin, Executive Director of the Alzheimer Society, to announce an innovative project that will enhance the safety and security of people with Alzheimer Disease and provide assurance to families and caregivers of those who have this disease.

As Minister of Health and Minister Responsible for Seniors, it gives me great pleasure to announce that Health Canada has approved a contribution of \$349,200.00 to the Alzheimer Society of Canada for the establishment of a ***Nation-Wide Alzheimer Wandering Persons Registry***.

I think it is fitting that we are announcing this project today -- the beginning of Seniors Month in most of Canada. This initiative will contribute to the health, well-being and safety of thousands of Canadians who are either affected by Alzheimer Disease or who have caregiving responsibilities

Alzheimer Disease is not a normal part of aging. But unfortunately, it is a disease that will be affecting an increasing number of Canadians over the years to come.

The Canadian Study of Health and Aging (1991) estimates that there are more than 250,000 cases of dementia among Canadians over the age of 65, almost two thirds of whom suffer from Alzheimer Disease. This represents eight per cent of this age group. The prevalence rises to twenty-six per cent at ages 85 and over.

With the aging of the "baby-boom" population, it is anticipated that the number of cases of Alzheimer Disease will reach 387,000 by the year 2021. Clearly, the implications of this disease can no longer be ignored.

No one knows exactly why people with Alzheimer Disease wander. What we are certain of is that these people are particularly vulnerable when they do, whether it be from exposure, darkness or unfamiliar environments.

Whatever the reason for it, wandering can be a constant worry for family members and other caregivers. The dilemma for many of them is how to provide both safety and protection without taking away the person's freedom of movement.

With no known cause or cure, Alzheimer Disease has been called "the worst of all diseases", not only for its effects on the people who have it, but also for what it does to the lives of those around them.

It is my hope that the *Nation-Wide Alzheimer Wandering Persons Registry* will offer a safety-net. The Registry will provide security and comfort to families by providing community police forces with information to trace and identify missing individuals. And through this project, the federal government will help to relieve the strain on caregivers and the community.

The establishment of a *Nation-Wide Alzheimer Wandering Persons Registry* also illustrates the importance of collaboration and partnership between the government and communities to address an important health and safety issue that will be affecting an ever-increasing number of aging Canadians and their caregivers.

The service involves a cooperative effort between police and the Alzheimer Society with the support of organizations such as the Canadian Medic Alert Foundation and the Block Parent Program of Canada.

I would like to extend my appreciation to my colleague, The Honourable Herb Gray, the Solicitor General of Canada, for his interest and support of this project. His perseverance and dedication to this innovative initiative will enable communities across Canada to have access to a reliable and effective information system, and provide training to police across the country in recognizing and identifying those who wander as a result of Alzheimer Disease. I thank him for his support.

I also congratulate the Alzheimer Society of Canada for developing this project, and wish them every success in its implementation.

Thank you.



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Speech / Discours

Speaking Notes
for
The Honourable Diane Marleau
Minister of Health

For presentation to
Physicians for a Smoke-Free Canada
Annual General Meeting
Ottawa, June 5, 1995



Check Against Delivery

34/95

Good evening. Thank you for inviting me to be a part of your Annual General Meeting this year. I really am pleased to be here because I believe Physicians for a Smoke-Free Canada are among my most important allies in the campaign to stamp out smoking.

For more than a decade, your organization has been instrumental in raising public awareness of the health hazards of cigarette smoking. Your help in developing the *Tobacco Products Control Act* is just one of the many examples of national leadership that you have demonstrated on this crucial health issue.

I know that every one of us here is committed to public health. But physicians have a special place in our society and a special role to play.

Let me tell you why I think they do. A few years ago, my department commissioned a national survey on health-risk perception in Canada. Among the objectives, one was to describe people's attitudes, perceptions, values, knowledge and beliefs pertaining to environmental health issues.

In one part of the survey, respondents were interviewed about their reliance on and confidence in various sources of information about health issues and risks.

You won't be surprised to learn that the information source most relied upon was the media. But, medical doctors were the second most relied upon source -- ahead of university scientists, provincial and municipal governments, and private industry.

As for the degree of confidence in a source of information, medical doctors were trusted substantially more than any other source.

At Health Canada, these results have tremendous significance. They mean that we need the active participation and collaboration of your community to achieve the objectives of our anti-smoking campaigns. And as one organization that represents that community, Physicians for a Smoke-Free Canada is one of Health Canada's most important partners.

You know, as well as I do, that smoking accounts for 20 per cent of all deaths every year in Canada. Moreover, tobacco use, as Dr. Kessler of the FDA has said, is a paediatric epidemic. The responsibility we share is to ensure that Canadians are aware of these statistics and their staggering consequences, but, more importantly, that they are motivated to do something about it. The challenge we face is to convince Canadians, especially young Canadians, why they should stop -- or better yet, never start -- smoking.

During the decade since the federal government launched the **National Strategy to Reduce Tobacco Use** in Canada -- in partnership with the provinces, territories and national health organizations such as yours -- we have learned a lot about what works and what doesn't. The **Tobacco Demand Reduction Strategy**, which we launched in 1994, is the latest federal contribution to the national effort.

Through the legislative, promotional and educational initiatives of the **Tobacco Demand Reduction Strategy**, we are working to convince people of the dangers, and the consequences of smoking.

I know we may have differences of opinion on some aspects of our approach. And I appreciate your concerns about some of the decisions this government has been obliged to make in dealing with tobacco issues. I also appreciate that you get impatient with governments, because you are the ones who treat people suffering from the effects of tobacco addiction and, far too often, are the ones who must deliver tragic health news to patients, which profoundly affects their families as well.

Taxation of tobacco products is one of the most effective tools in the government's tobacco control arsenal. As you know, I have always maintained that the reduction in tobacco taxes would be a temporary measure. The Minister of Finance, with the collaboration of the provinces, has recently increased taxes in Ontario, Quebec and Prince Edward Island. These are the first steps toward the equalization of tobacco taxes across Canada.

I am sure we are in agreement on the major thrust of our current public education campaigns and programs, which are geared to those at highest risk for addiction -- women, especially pregnant mothers, and the youth of this country.

Health Canada's recent anti-tobacco media campaign has been very successful. According to a recent survey, 89 per cent of English Canadians and 95 per cent of French Canadians were aware of the campaign and its messages.

The recent report on generic packaging of tobacco products prepared by the Expert Panel as part of our **Tobacco Demand Reduction Strategy**, is just one example of several key departmental initiatives.

We are carefully reviewing the implications of the Expert Panel's findings before deciding on the next step. We will consult with other federal departments about the international trade, contraband and economic implications of plain and generic packing. Any decision to further modify tobacco product packaging will have to take account of the Supreme Court's ruling, expected later this year. This is not stalling, as some have suggested; this is doing our homework and getting it right.

Over the course of the next few weeks, my department will also be releasing a series of studies and reports featuring the latest research on tobacco use. On Wednesday, we will distribute Cycle 4, the final cycle of Health Canada's Survey on Smoking in Canada. That will be followed by our Environmental Tobacco Smoke (ETS) study, funded under the **Tobacco Demand Reduction Strategy**.

And, as you know, my department has been evaluating changes in the nicotine content of Canadian cigarettes that have occurred over the past 25 years. Those results will also be available shortly.

I am confident that, as these findings are released, we will continue to educate Canadians about the dangers of smoking and the direct and dramatic impacts it can have on their health and that of their families.

Our research will also serve as a basis for legislative and program review -- to ensure that the resources that we commit to tobacco are effectively used.

On the international level, Canada's leadership in the area of tobacco demand reduction was recognized recently by Dr. Hiroshi Nakajima, Director General of the World Health Organization, who described Canada's comprehensive approach to tobacco control as an outstanding example of a well-thought out public health policy.

We have the same anti-smoking obligation internationally, particularly in developing countries. We are all aware of the rapidly changing tobacco environment and the marketing strategies of the tobacco industry. As its influence declines in North America, it is manoeuvring into new markets in the developing world.

I am convinced we are gaining momentum in this struggle on the international front. I have just returned from Vancouver, where I celebrated "World No-tobacco Day" with the U.S. Secretary of Health and Human Services, Donna Shalala.

We committed to close cooperation in developing and implementing strategies to curb tobacco use in both our countries, because we know tobacco addiction knows no borders.

As I stated during World No-tobacco Day, Canada can play a critical and supportive role in meeting those challenges, given our status as a world leader on tobacco and health. We in the industrialized world must share our knowledge and experience with the people and governments of developing countries.

Last month, Canada played a major role in insuring the adoption of the World Health Organization resolution to investigate the feasibility of developing international instruments such as guidelines or an international convention on tobacco control.

Here at home, we also have to recognize that while we have reduced tobacco use overall, our success with some groups -- particularly young Canadians -- has been limited, or even negated, by other competing factors such as peer pressure and the marketing efforts of the tobacco industry.

That is why I invite you to work closely with Health Canada and all the other governments, professional associations, and voluntary partners committed to a smoke-free Canada. Because, united, we stand a much greater chance of eliminating tobacco addiction.

In your own communities, and in your offices on a daily basis, you are in the best position to promote good health and deliver prevention messages directly to your patients.

Physicians for a Smoke-Free Canada serves an invaluable function in counselling Canada's doctors to advise their patients of the health hazards of smoking, and to direct them to the many programs and services available at the community, provincial and national levels.

That is why my department funded a Physicians for a Smoke-Free Canada project, to assist you and other primary health care providers working with women patients who smoke by developing a bilingual resource kit which will offer gender specific approaches to dealing with this very serious women's health concern.

The most critical issue, ultimately, is not how many Canadians are smoking, or even their age or gender. What really matters is whether **any** Canadians are smoking. Because as long as Canadians smoke, we will have a national health problem.

Reducing tobacco use will save Canadian lives.

Let there be no doubt about my personal determination to succeed with our anti-smoking strategies, or of my department's on-going commitment to reduce tobacco use as a national health priority.

I look forward to working closely with you to ensure we will see the day when, instead of lamenting 40,000 preventable deaths each year, we will celebrate 29 million Canadian smoke-free lives.

Thank you.



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Speaking Notes
for the
Minister of Health,
The Honourable Diane Marleau

Annual General Meeting
Health Executive Forum
Sunnybrook Health Sciences Centre
Toronto, June 19, 1995



Check Against Delivery

37/95

Canada

Good evening, ladies and gentlemen.

I am pleased to be here tonight because you and I are part of a team. Our health system is a collective effort that involves governments, health care providers, medical practitioners and a host of others. As managers of hospitals and community health service agencies, your role is critical to the success of the undertaking.

This evening, I want to talk to you about a topic that is relevant to all of us – how to continue to provide Canadians with the world's best quality health care in an era of harsh fiscal realities.

I know that, as health care managers, you are already doing more with less. At Sunnybrook Health Science Centre the record is well known. The centre has set an example for all of us – not just by cutting costs, but also by increasing patient services at the same time. And I know that the success here is being emulated in organizations across the province.

The development of a new remuneration scheme for physicians in the teaching hospitals in Kingston is one example. The recent agreement covering payment for clinical services, teaching and research will enhance their efforts in all three areas. Other innovations include new approaches at the Toronto and Mount Sinai hospitals – outsourcing patient food services, maintaining supply inventories, facilities management and energy management.

Innovative solutions, reinvestment of scarce funds, and value for money are challenges we all face. But while learning to cope with all this change, we can also take comfort in the things that remain constant.

One of those constants is the federal government's commitment to medicare and the five principles on which it is built. As Finance Minister Martin said in his Budget speech last February:

... the conditions of the *Canada Health Act* will be maintained. Universality, comprehensiveness, accessibility, portability and public administration. For this government those are fundamental.

Since the Budget, the Prime Minister and I have reiterated that message. I have also pointed out on numerous occasions that nothing in the Budget will change my ability to enforce the *Canada Health Act* principles.

Let me remind you how the *Canada Health Act* works. As you know, the federal government transfers funds to the provinces in support of health and post-secondary education. These are the EPF transfers -- the Established Programs Financing arrangements -- that you are all familiar with. They consist of tax points and hard cash.

The purpose of the *Canada Health Act* is to establish the criteria and conditions that must be met by provincial health insurance plans before full payment can be made under EPF.

The CHA criteria are more generally known as the five principles of medicare. They are universality, accessibility, comprehensiveness, portability and public administration. And the fact is that the federal government can reduce or withhold health care transfer payments if a province does not meet any of these criteria.

In the event of extra-billing or user charges, the Act requires that I impose dollar-for-dollar automatic penalties. For other violations of the CHA criteria, there is provision for penalties as well. If my consultations with the province do not remedy the situation, the matter is referred to cabinet for determining a penalty in accordance with the gravity of the default. This means that cabinet can order a reduction in the cash contribution of federal transfer payments or a withholding of the entire amount.

The recent federal budget did not change any of these enforcement mechanisms. They remain the same. I can continue to impose mandatory penalties for extra-billing and user fees -- including facility fees in private clinics that provide medically necessary services. I will be doing exactly this on October 15 with respect to any province which continues to permit facility fees. And the federal government can still apply other penalties in response to violations of the criteria of the Act.

I hope this debunks one myth about the budget -- that the federal government has lost its capacity to enforce the CHA. Let me now debunk another myth -- that the federal government is withdrawing from financial support of medicare.

This year, under EPF, we are transferring \$15.5 billion to the provinces and territories to support their health care programs. In Ontario alone, the amount is \$5.8 billion. This is an increase of 1.5 per cent over the previous year, and that was up from the year before. Next year, support for health, post-secondary education and social assistance will be combined in the new Canada Health and Social Transfer. The total amount paid to Ontario will be \$9.6 billion dollars.

That is a substantial amount of money, ladies and gentlemen. It represents the federal government's continued commitment to health and social programs. Clearly, we are not withdrawing from the field.

There is a third myth I want to address -- the idea that the *Canada Health Act* restricts provincial flexibility in delivering health care services to residents. In fact, the provinces are free to organize and deliver services however they wish -- as long as the five principles of the *Canada Health Act* are respected.

This will not change under the combination of the CHST and the *Canada Health Act*. Provinces already have widely different delivery systems. More diversity may well develop without compromising the principles. Provided the principles are upheld, I will certainly not impede such diversity.

This is another opportunity for me to acknowledge and applaud the tremendous innovations that have been undertaken by you and your colleagues at the provincial level. I understand that more than fifty per cent of all Ontario hospital surgery is now done on an out-patient basis. This represents significant savings to the health system. Community-based services are another example of cost-effective innovation.

So far, I have been talking about how the federal government will continue to defend Canada's health care system. Now I'd like to tell you why.

One reason is obvious. As Canadians, we cherish the personal and family security that our medicare system provides. But the benefits extend much further. Medicare also contributes to Canada's *economic* security.

I want to spend a few moments discussing that contribution. At a time when some dismiss medicare as an unaffordable luxury, I want to give you the hard numbers and facts that prove its important contribution to our prosperity.

Medicare, as you know, is an insurance program. In effect, we have used our ingenuity, foresight and tax dollars to create a giant insurance pool covering all Canadians.

Health care needs and their related costs that medicare covers would generally exist no matter what system we had in place for paying them. As we all know, health services are never free. Public or private, someone always pays.

But some costs add nothing to positive health outcomes. The first economic benefit of our medicare system is that we have administrative overhead costs well under control.

We have one organization in each province that provides insurance coverage, not dozens or hundreds, as in an American state. We do not have the elaborate and costly processes that private insurers need to rate the risk of people or groups.

Think for a moment about private car insurance and the different premium structures for young, old, men, women, experienced and accident-prone drivers. I think you'll get the picture. We do not require the intensive control systems private insurers use to monitor premiums and payments. Simply put, we don't spend much on overhead.

One fact will put it in perspective. We spend only 1.1 percent of our Gross Domestic Product on health care administration. That's about \$272 per person. The United States spends about two and a half times that much -- about \$615 (US) per person. And not one of those billions of additional dollars goes to patient services.

The second related economic benefit of Canada's medicare system is a better record of controlling costs. Each provincial and territorial government is the predominant buyer of health care in its jurisdiction. This gives it enormous leverage to get the most service at the best price to taxpayers. It can negotiate fee structures and service costs in ways that no private insurer could hope to. It can shift its spending to achieve more cost-effective outcomes.

In response to the fiscal crunch that has affected all of us, and faced with growing evidence from here and abroad that more health could be derived with the same or even less dollars in total, governments have used that leverage. Since 1992, real public health expenditures have been declining. Preliminary spending estimates for 1994 suggest that public spending on health costs *declined* in real terms by about 1.4 percent.

In comparison with the public sector record, the private health sector has had little success in cost control. It accounts for more than a quarter of all health spending. And its costs have been growing at more than 6 percent per year since 1990. Individuals and insurers in the private sector have found little leverage to bring those costs under control.

What are the overall financial impacts of medicare as opposed to a system with multiple payers? The best way to show it is by comparison with the United States.

The relative difference in spending between us and our neighbour to the south saves our economy 30 billion dollars a year. That is why we have large employers, together with seniors, working people and health activists, warning against the erosion of medicare. They know that costs will go up significantly in a two-tier health system. And they know another thing. We will all foot the bill.

They know it because they see it now. Companies pay anywhere from three to five times more for employee benefits in the U.S. than in Canada. And yes, that cost includes taxes. Medicare has helped attract the investment of companies such as Ford, Toyota and Chrysler to Canada. This has created more jobs for Canadians.

A stronger economy and a healthier population - medicare contributes to both. And so does my Department -- because there is much more to Health Canada than transfer payments and health insurance. I want to end my remarks on that theme because I know -- from my travels across Canada -- that people are often not aware of the full range of my department's responsibilities.

They expect governments, hospitals, industry and health care practitioners to work as a team to meet goals set years ago, such as access and universal coverage that are still valuable, and still appropriate. And they are also counting on us to meet new responsibilities in dealing with such disparate developments as new technology and an aging population.

In closing, I invite you to join with me in rededicating ourselves to the team that has served Canadians so well over the years. Together, we can continue to meet their expectations.

Thank you.



Speech / Discours

Speaking Notes
for the
The Honourable Diane Marleau
Minister of Health

World Conference on Hypertension Control
Ottawa, June 22, 1995



Check Against Delivery

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Thank you, Dr. Genest, for your kind introduction. Please accept my thanks and congratulations for your excellent efforts in helping to put this conference together.

I would like to express my sincere appreciation, as well, to Dr. Detlev Ganten and the World Hypertension League for choosing Canada as host for the World Conference on Hypertension Control.

I am honoured to be joined on stage by some of the world's leading pioneers and eminent experts in the field of hypertension. It is my pleasure to bring greetings to you from Prime Minister Jean Chrétien. On behalf of the Government of Canada, I extend a special, warm welcome to our international delegates. I hope your stay in our nation's capital will be as enjoyable as it is educational.

By choosing to attend this Conference, each one of us is acknowledging that there is much to learn from each other if we are to prevent and control hypertension. The "silent killer" works in mysterious ways.

In our search for answers, one is confronted with many questions. Why are so many hypertension patients asymptomatic? As the vast majority of hypertension cases result from unknown causes, are there new clues that will improve diagnoses? How can we get beyond treating the numbers?

I am encouraged to see that those who developed the agenda for this meeting are asking the right questions. This conference will produce many of the answers we seek.

One thing is certain. No matter what country or community we represent, each of us recognizes that the cost of hypertension -- in terms of health, quality of life and economic impacts -- is enormous.

And the situation could potentially worsen. As the world accelerates into the information age, more and more global citizens find themselves living in stressful societies that have adopted the industrialized world's bad habits. Each day, there are fewer places free from the adverse effects of a sedentary lifestyle, too much smoking, alcohol consumption and high-fat diets.

Certainly, in this country, we live in an environment which permits implicit support for many harmful practices, with decidedly unhealthy results. Almost one half of adult Canadians are overweight -- a primary contributing factor to diabetes, hypertension and other forms of heart disease and stroke.

In almost equal proportions, many of those individuals will become part of the annual statistics. Of the total deaths each year in Canada, 38 per cent are due to cardiovascular disease.

Aside from the personal price individuals pay, there is a societal cost as well. In Canada, one in every five dollars spent on hospital operating costs, and one-tenth of all medical expenses, are for the care of patients with cardiovascular disease. That translates into roughly seven million patient days in hospital and 12.5 per cent of all prescriptions dispensed.

The disability rate related to stroke accounts for nearly half of the patient days in hospital for cardiovascular disease. For Canada, this means between \$350 and \$400 million per year. Such expenditures exact an enormous toll on our health care budgets.

In Canada, our approach has been at the community level. It is here, we believe, that the battle over hypertension will be won. There is a national consensus that early awareness and lifestyle modification are essential to reduce the personal and economic burden of cardiovascular disease.

That is why hypertension control is a critical element of Canada's heart health strategies. We know that if we can control high blood pressure we can control heart disease, including stroke.

We also recognize the multiplier effect of heart health. By preventing cardiovascular disease we can reduce the incidence of some common types of cancers, kidney failure, lung, liver and even some eye diseases.

Ministers of Health and health practitioners are working to ensure that the benefits of prevention are extended to all Canadians. This includes groups with special needs such as the elderly, the economically disadvantaged, Aboriginal peoples and women.

As a result of our prevention and health promotion measures, we have experienced considerable success in our efforts to conquer cardiovascular disease. Despite the disturbing statistics I cited earlier, the national death rate from heart disease and stroke has been cut in half over the past two decades -- due largely to healthier lifestyles and better treatment.

Canada has one of the lowest stroke mortality rates in the world. In fact, the decline has been so impressive that about 14,000 stroke deaths are now averted in Canada every year. This is a major success for which both our universal health care system and health promotion programs can take credit.

Through these efforts, Canada has become a recognized world leader in the field of heart health. In 1992 we hosted the International Heart Health Conference in Victoria, British Columbia, which produced the **Victoria Declaration on Heart Health** -- a policy blueprint to reduce, and eventually eliminate, cardiovascular disease.

The Declaration provides a prevention agenda for all and makes a poignant point: we already have the scientific knowledge to prevent most cardiovascular disease. However, there is a gap between what we know about prevention and the lifestyles of many Canadians.

And that is where the Canadian Heart Health Initiative comes in. The Initiative is a national strategy jointly funded by Health Canada and the provincial ministries of health to prevent cardiovascular disease and bring about healthy public policies. I want to stress that its success relies on strategic alliances. The federal and provincial health departments are partners in the Canadian Heart Health Initiative, along with the Heart and Stroke Foundation of Canada, as well as over 300 professional associations, scientific societies and community coalitions.

I want to pay tribute to one of the key organizations that has helped to advance this Initiative -- the Canadian Coalition for High Blood Pressure Prevention and Control, under the leadership of Dr. Arun Chockalingam from my department.

The Canadian Heart Health Initiative has accomplished much. It has fostered consensus and shared values through coalition building and collaboration.

From the outset, those involved in the Initiative recognized the importance of a comprehensive database for program planning and evaluation. The result is the **Canadian Heart Health Database**, the largest of its kind in the world. The database -- comprised of provincial heart health surveys -- is a key resource for research and health policy development. In the spirit of partnership, I would like to share with you some of the latest findings culled from our national database.

Today, it is my pleasure to officially release "*Canadians and Heart Health: Reducing the Risk.*"

The data presented in this publication has been compiled from Provincial

Heart Health Surveys carried out between 1986 and 1992. This is the first time that the complete **Canadian Heart Health Database** for all the provinces -- comparing risk factor data on approximately 23,000 people aged 18 to 74 -- has been available.

Among the many findings, risk factor prevalence is generally lower in the western provinces than in the rest of Canada. Not surprisingly, the excess prevalence of cardiovascular disease risk factors in the Atlantic provinces and in Quebec matches the higher cardiovascular disease mortality rates in those provinces.

Other findings are more worrisome. The surveys show, for instance, that only 18 per cent of Canadians are aware that hypertension is a key risk factor for cardiovascular disease -- despite the fact that high blood pressure is recognized as one of the most important modifiable factors contributing to heart disease. These results underscore the need for strengthened preventive measures.

"Reducing the Risk" constitutes a wealth of information that will inform future strategies. It will be particularly useful to the coalitions, groups and individuals working in the field. It should bolster efforts by focusing on the risks and the resources required to reduce those risks.

I am confident this report's findings will be equally helpful to our international partners. We have gained much from the knowledge of experts around the world and are committed to sharing our experiences with you. Just a few weeks ago the 2nd International Heart Health Conference, held in Barcelona, released the Catalonia Declaration on Investing in Heart Health. It states, unequivocally, that investing in prevention reduces suffering for untold millions, eliminates unnecessary health care costs, increases productivity and thus contributes to economic prosperity.

International conferences such as this help to advance our efforts in meeting the challenge posed by cardiovascular disease. They expand our knowledge and bring to light some of the alternative approaches to treatment and control of hypertension.

Over the next few days, you will benefit from each other's experiences and borrow best practices which may work well in our own countries. Working together, we can form a united front in our efforts to manage -- and some day eliminate -- cardiovascular disease. That work must begin right here.

We know we have the capacity to virtually eliminate this source of unnecessary death and disability. This conference provides clear evidence we also have the will.

I have every confidence that a hypertension-free world is within our grasp.

Thank you.



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Publication

Speech / Discours

Speaking Notes
for
the Honourable Diane Marleau
Minister of Health

Announcement of funding for
The HIV/AIDS Treatment Information Network
Primrose Hotel
Toronto, June 29, 1995



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39/95

Canada

I would like to wish my colleague, Mr. Bill Graham, M.P. Rosedale and all those here today a very good afternoon. I'm honoured to be with you today as we mark another milestone in the implementation of the **National AIDS Strategy**.

At the outset, I want to thank the members of the National Advisory Committee of the HIV/AIDS Treatment Information Network for their commitment to making this innovative Network responsive to the needs of persons living with HIV and AIDS and their caregivers across the country.

The collaborative efforts of the Committee reflect the broad partnership approach to AIDS care, treatment and support. This partnership approach is a key component of the federal government's **National AIDS Strategy**.

Today, I am announcing funding support under Phase II of the **National AIDS Strategy** that will impact directly on your work. In accordance with the needs identified by the AIDS community, Health Canada is contributing \$4.9 million over three years to help establish the national **HIV/AIDS Treatment Information Network** by late 1995.

Those living with HIV/AIDS, and everyone involved in the care and treatment cycle, will benefit greatly from this new Network. It will provide reliable, up-to-date treatment information -- in both official languages -- to persons living with HIV disease -- and their caregivers -- in all regions of the country.

The goal of the Network is to collect, package and disseminate treatment information as quickly as possible so that it can be put to use by those who need it most. By providing better, faster and more comprehensive information, the Network will help persons living with HIV/AIDS and their caregivers to make more informed decisions about treatment options.

The funding -- provided through Health Canada -- reflects the federal government's ongoing commitment to persons living with HIV and AIDS. The Network is one of a number of National AIDS Strategy initiatives aimed at strengthening both formal and informal support systems for those affected by HIV and AIDS.

The funding will be directed to the Community AIDS Treatment Information Exchange -- or CATIE -- which will run the Network from its College Street location in Toronto. CATIE, as many of you know, is a non-profit, community-based organization committed to improving the health and quality of life for all people living with HIV/AIDS. Since its founding five years ago, CATIE has focused its efforts on providing AIDS treatment information. CATIE will use this funding to implement the service and hire and train staff to handle information inquiries. Wherever possible, the organization will hire those living with HIV to help run the Network.

Another innovative aspect of this information service is that it will be entirely client-oriented and client-driven. This means, for example, that if a person living with AIDS in Calgary reads about a new AIDS vaccine in a local newspaper, and wants more information, this person can call the Information Treatment Network on a "1-800" line and speak directly to an information counsellor here in Toronto. The counsellor can provide the latest information on the vaccine in lay terms and tell the caller where the vaccine will be available in the Calgary area and who to contact for additional information.

For caregivers and researchers who want detailed technical information, the Network will offer access to the best and latest material on the diagnosis and treatment of HIV infection and related conditions. It will also provide reliable, up-to-date information on clinical advances in the field of HIV infection.

All information will be provided on a confidential basis to protect the privacy of end users, and, as I mentioned earlier, treatment information will be available in English and French. It's anticipated that many persons living with HIV will wish to access the service by telephone. AIDS service organizations will likely access the Network through computer modem.

The **HIV/AIDS Treatment Information Network** is the result of considerable national consultation with the AIDS community, and particularly with those living with HIV/AIDS. Once established, a key priority for the Network will be its responsiveness to the changing information needs of persons with HIV and their caregivers. The Network will therefore need to develop strong working partnerships with research and voluntary organizations, and with professional health organizations across the country.

Another priority will be to maintain a high degree of accountability to end users. This is where the National Advisory Committee comes into play. With representatives from all of our major AIDS partners -- including the Canadian Hemophilia Society, the Canadian Public Health Association and the Canadian AIDS Society -- the committee will be in a position to ensure that the Network addresses the concerns of the entire HIV/AIDS community in Canada.

As you can see, this unique combination of practicality, responsiveness and accountability make the **HIV/AIDS Treatment Information Network** an immensely important initiative. I'm convinced it will make a difference for those living with HIV/AIDS, allowing them to better manage their illness and to gain more control over their health and quality of life.

For those of us committed to AIDS care, treatment and support in Canada, the establishment of this innovative Network is an achievement in which we can all take pride.

Thank you.



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Speaking Notes
for the
The Honourable Diane Marleau,
Minister of Health,

19th International Congress
of Chemotherapy
Montreal, July 16, 1995



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Canada

Distinguished delegates,

On behalf of the Government of Canada, I want to welcome delegates to our country for the 19th International Congress of Chemotherapy.

Canada is an appropriate site for an event of this significance. Montreal, in particular, has established itself as a world-renowned centre of research, treatment and pharmaceutical innovation.

The wealth of expertise that our country has in the field of chemotherapy is proven by the respected men and women who have organized this event. I want to congratulate them for an impressive program.

Their work in organizing this congress is one example of their contribution to improving the uses and effectiveness of chemotherapy. It is also recognition that they are part of a larger international effort.

Around the world, researchers and practitioners such as you are doing work that matters to literally millions of Canadians -- those with cancer and infectious diseases, and the loved ones who share their fight. That work has had measurable results.

In 1990, approximately 413,000 Canadians were alive who had been diagnosed with cancer within the previous decade. More than one third of these people had lived more than five years since their initial diagnosis. Many of them had chemotherapy to thank for their success in fighting cancer.

This year alone, a further 125,000 Canadians will be diagnosed with cancer. They will look to advances in treatments such as chemotherapy for answers and hope.

The use of chemotherapy to address infectious diseases is also critical. It has been instrumental in controlling many diseases and eradicating others. In addition to chemotherapy, vaccines play another important role in our public health efforts. For example, while the Hepatitis B vaccine is used successfully in the prevention of infection, it also prevents the development of cancer of the liver. Another example is the BCG vaccine, which is accepted as a therapeutic agent for treating cancer of the bladder and is also known to be used in the prevention of tuberculosis especially in countries where the incidence of tuberculosis is high.

At the same time, we know that the appearance of resistant strains of diseases, such as tuberculosis, represent a major public health challenge. We are learning that, in a world of easier global travel, domestic progress in infectious disease control in any one country alone is not enough.

All these factors demonstrate why Canada has taken health issues seriously. Many of our health care priorities relate to health matters that are related to the use of chemotherapy.

My department is a partner and facilitator of medical research and public health work in Canada. In fact, Health Canada is responding to changing needs by reinvesting money in the high priority area of public health intelligence, this despite the current fiscal realities.

In addition, through community-based programs such as our **Brighter Futures** initiative, we have funded specific activities -- for example, the Canadian Childhood Cancer Program. This recognizes the importance of this issue, the progress that research has made, and our commitment to still greater advances. Chemotherapy has been, and will continue to be an important part of that progress. Most notable in this regard is the tremendous reduction in the mortality rates associated with cancers such as childhood leukaemia.

There are many other examples of work that we are funding directly or through Canada's Medical Research Council. We also work with the National Cancer Institute of Canada, as well as with similar bodies in Canada's provinces, and with researchers at many hospitals and universities across the country.

International contacts are an essential element in this process. They have been for a very long time. But now we have many more tools that break down the barriers of time and space to link us in a shared quest.

Imagine what Louis Pasteur could have done with the Internet and through conferences such as this one!!

Whether we speak of infectious diseases or cancer, people around the world benefit from the work you are doing. This congress allows you to enhance the importance of that work and communicate it so that more can benefit, and sooner.

I wish you every success. Thank you.



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Speaking Notes
for
The Honourable Diane Marleau
Minister of Health

Cancer Research Foundation Fundraiser
Sudbury, October 18, 1995



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Canada

Good evening, ladies and gentlemen. Thank you for inviting me to be here tonight.

It's always a pleasure to be home in Sudbury. I am especially delighted to see so many friends in the audience.

By coming here tonight to lend your support to the Cancer Research Foundation, you are providing another example of something I have always said about our region. The people of Sudbury care -- and they show it.

And the people of Sudbury have many reasons to be proud of our region. It's a great place to live -- and we know it.

One of the most important reasons for pride is the accomplishments of the Northeastern Ontario Regional Cancer Centre. For leadership in the fight against cancer, more and more people are looking to Sudbury.

- ◆ Dr. Stephen Gluck has been invited to talk about the centre's programs throughout Ontario and in several foreign countries.
- ◆ Ours is the first centre in Canada to perform stem cell transplantation on an out-patient basis -- a wonderful gift for patients and their families.
- ◆ Health Canada recognizes your very important work in the area of cancer research. I am very pleased to announce that my department is providing funding of over \$430,000 to the Northeastern Ontario Regional Cancer Centre to study a variety of risk factors thought to lead to prostate cancer.

I am sure that this study will help us understand possible causes of prostate cancer, and point the way to prevention.

Of course, this is also Breast Cancer Awareness Month. As many of you know, breast cancer research is an area to which I have been personally committed for a long time.

The federal government has demonstrated its commitment in a number of ways. One is through funding -- a total of \$25 million over five years.

Another has been by bringing people together to shape common ways we

can provide women with access to information, effective screening for the disease, and treatment programs.

It was two years ago next month that Health Canada joined forces with the Canadian Cancer Society, the National Cancer Institute of Canada, the Medical Research Council and the Canadian Breast Cancer Foundation to sponsor the National Forum on Breast Cancer.

The Forum produced recommendations on the service and support women need -- recommendations that will serve as guideposts on the path towards dealing with breast cancer in Canada.

The approach we are taking reflects the approach Canadians have taken to health care issues for decades. Bringing people together. Dealing with problems on a national basis. Ensuring the system addresses everyone's needs -- and does so equitably.

That leads me right to the subject I want to focus on this evening -- equal access to health care.

As you know, Canada's health system is world renowned. Canadians were proud when the United Nations told us that it is one of the factors that make our country the best in the world in which to live. But we weren't surprised. Because the quality of health care in this country is something of which Canadians of all walks of life have long recognized and depended upon.

As the Prime Minister stated in the House of Commons not long ago, medicare is the one element of our social safety net that Canadians believe in most strongly.

And Canadians recognize that one of the key ingredients of the success of our health system is national standards.

It was more than a decade ago that Parliament clearly spelled out the national standards that form the foundation of our health system. These standards are the five principles of the *Canada Health Act*.

The first of these principles is **universality**. All residents in a province must be insured by a provincial health care plan if it is to receive federal financial support.

The second principle is **portability**. Canadians must be able to maintain their health coverage when they move from one part of the country to another.

Principle three is **public administration**. Health insurance must be carried out on a non-profit basis accountable to a public authority.

The fourth principle is **comprehensiveness**. All medically necessary services provided by hospitals and doctors must be insured.

And the fifth principle is **accessibility**. In our health system, there must be no barriers to necessary health care. No extra-billing, no user fees. The Parliament of Canada has stated that principle clearly. The people of Canada support it deeply.

When you think about it, it is the principle of equal access that makes our health system so important to our quality of life. Without that principle, few could feel fully secure that their essential health needs will be met.

It is the principle of equal access that lifts the worry from our minds. The worry of how you will meet your medical bills if you lose your job. The worry of what you will do if a member of your family needs an expensive medical procedure.

However, the principle of equal access doesn't just ease worry. It advances hope. It gives every Canadian an equal stake in an improved health system. It gives every Canadian an equal opportunity to benefit from the work of groups like yours.

The principle of equal access has turned the Canadian health system into a level field upon which all Canadians stand.

But in some provinces the field is being tilted. It is being tilted against the middle-class and the poor. That has been happening by allowing semi private clinics to charge their patients facility fees for services that are deemed medically necessary.

Some may ask what is wrong with this practice.

If some people are able and willing to pay for speedier treatment, shouldn't they be allowed to dig into their bank accounts and pay the cost? Doesn't that shorten the line for everybody else to get treatment? Doesn't it make more resources available to health care in general -- and take pressure off the system?

The answer to each of these three questions is the one we have given: A firm no.

The reason is simple. Semi-private clinics do not just bill their patients. They bill the taxpayers. They charge their patients facility fees with one hand -- while charging the government for physician fees with the other.

User fees of this kind don't take pressure off the system; they take resources away from the system. Because the facilities may be semi-private, but the funding is semi-public. They take tax dollars away from the public health system.

The impact of these lost dollars is felt. It is felt by the middle-class. It is felt by single mothers. It is felt by seniors. The impact is felt by every Canadian who cannot afford to pay the steep facility fee for medically-necessary services. Because if you allow the wealthy to buy their way to the head of the line, you push everyone else to the back.

It is subsidized queue-jumping -- and it doesn't make the queue any shorter. It sets up an express line for those who can afford it -- and lengthens the line for those who can't.

What it comes down to is this: Those who can afford the facility fee get a subsidy. Those who can't, pay a subsidy.

That clearly undercuts the principle of equal access to health care. And poses a significant threat to one of the aspects of Canadian life that is most important to us.

How is the federal government dealing with that threat?

We are dealing with it the Canadian way -- prudently, pragmatically, and fairly.

We initiated the process almost a year and a half ago. In June of 1994, a conference of federal, provincial and territorial deputy ministers of health directed a working group to collect information on private clinics in Canada. Three months later, at a meeting of Ministers in Halifax, there was virtual unanimity on the urgent need to take whatever steps were required to regulate the development of private clinics in Canada.

I took those steps. Last January, I wrote to all provincial and territorial health ministers, spelling out the federal government's interpretation that facility fees charged by private clinics for medically necessary services are user fees. As such, they are a financial barrier to access and a violation of the accessibility principle of the Canada Health Act.

In my January letter, I said that the federal government would reduce its payments to provinces that do not end the practice.

But no one was asked to change their policies at the snap of a finger. We did not want to cause undue hardship for provinces where legislative or regulatory changes were required. That is why I provided more than nine months for provinces and territories to make adjustments. My officials consulted with interested provinces and territories during that time.

Three days ago, we reached the October 15th deadline. As of that day, the policy came into full force. If a province says a service is medically necessary, the full costs must be covered by public health insurance. Otherwise, the penalties provided under the Canada Health Act must be invoked. Actual deductions from provinces and territories in violation of the Act could begin as early as November.

Did we give the provinces sufficient time to adjust their regulations? Obviously we did, because so far at least one province has made the necessary changes.

Did we target any one province? Absolutely not. At the time I spelled out the policy, a number of provinces were affected.

Did we act arbitrarily? Far from it. There were three meetings of federal, provincial and territorial ministers or deputies prior to the time I spelled out the policy. Since that time we have had two meetings of all ministers, three meetings of officials, and numerous bilateral meetings.

Is this the end of consultation on the issue? Not at all. I welcome renewed discussions to end the practice of private clinics charging facility fees for medically necessary care. But it is essential that we see concrete proposals.

We are always prepared to talk. We are always willing to listen. But we have begun to act.

The important step we have taken in this area need not prevent us from working closely with the provinces on the broad spectrum of health issues. Ministers of health are working together to develop a vision of the future of the health system.

Our work is in close cooperation with the National Forum on Health. That body, chaired by the Prime Minister, is searching for ways to improve both the health of Canadians and the efficiency and effectiveness of health services.

Canada's health system has earned world-wide praise. But laurels are not something to rest on. They are something to build on.

There are many challenges to our health system. And we are working together on ways to meet those challenges. It will require cooperation. And it will require innovation and flexibility.

But there is one thing on which we must always stand. That is the principle of equal access. We cannot have a two-tier health system in Canada -- especially a system in which those on the bottom tier subsidize those on the top.

Ladies and gentlemen, the federal government is determined to make sure that Canada's health system continues to be the best in the world. And we are determined to ensure that all Canadians are able to benefit fairly from it. We are committed to preserving a level field on which all Canadians can stand equally. We are taking the steps that are necessary to ensure that the fundamental principle of equal access remains a reality for all Canadians.

Thank you and good night.



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Speaking Notes
for
The Honourable Diane Marleau
Minister of Health

Huntington Society of Canada
National Workshop
Sudbury, October 21, 1995



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50/95

Good morning. I want to extend greetings from the Government of Canada, and my congratulations to you on this impressive annual workshop.

The depth and scope of discussion taking place this weekend is a testament to the strength of your organization, and your commitment to dealing with key issues affecting your members.

As a former health sector volunteer in Sudbury, I admire your track record in my community and elsewhere across the country. I want to take this opportunity to express my appreciation for your innovative and effective work.

The Huntington Society of Canada has come a long way in a relatively short time. Since its founding a little more than two decades ago, the society has grown from a group of 29 families in Cambridge, Ontario to a vibrant national network of individuals helping each other and working toward finding a treatment and cure for Huntington's disease.

Your success is important to Canadians for two reasons:

First, you are **making a difference**. Your efforts in providing support services, creating public awareness and in research are helping to improve the quality of life for people with Huntington's disease and their families.

Second, you are **setting an example**. You are showing what voluntary health organizations in this country can achieve through strategic collaboration with government and health care professionals.

The national voluntary health sector is made up of more than a

million Canadians whose efforts are focused on meeting the health care needs of target population groups across the country.

These volunteers are instrumental in helping us move away from an institutional approach to health care toward a more community-based approach. And as many of you will agree, this often translates into more immediate, more practical and more compassionate responses to health care needs.

Health Canada is continually working to increase opportunities for voluntary organizations to work with us in our mandate of helping Canadians maintain and improve their health.

One mechanism through which we collaborate with the voluntary sector is the Grants to National Voluntary Health Organizations Program. This program provides short-term financial assistance to help selected national organizations improve operations ... broaden their base of support ... optimize management skills ... and develop concrete strategic plans. The goal of the program is to help these organizations deliver effective programs and services to Canadians and become strong and self-sufficient.

Just recently, I have approved grants for 34 national voluntary health organizations totalling \$2.4 million for 1995-96. Among these grants is a \$60,000 grant to the Huntington Society to help with your National Chapter Development Program and Volunteer Leadership Development. All of the associations Health Canada has funded encourage public participation in the planning and delivery of health services, and all proactively identify and respond to emerging health concerns.

Your work toward a cure and treatment of Huntington's disease,

and your efforts to improve the quality of life for people with the disease and their families have been remarkable.

And you can take a great deal of pride in the fact that your research support was instrumental in the discovery of the Huntington's disease gene in 1993.

What strikes me most about your overall approach is the degree of organization and vision you bring to your work. Your success can be attributed to clear and realistic goal setting in research, individual and family services and public education.

And you have not been content to rest on your laurels. Your most recent activities -- including summer camps, your membership newsletter, your video to help increase volunteer recruitment, your new family support groups, and your outreach to rural areas demonstrate that your vision remains progressive and people-centred.

It is more than apparent that the Society is well-managed, with a strong and loyal volunteer base. Your programs and services have expanded to meet the needs of your members. Your plans for increasing services in the coming year are both pertinent and realistic. Most importantly, the Huntington Society of Canada is moving toward self-sufficiency. This is the true hallmark of success for any national voluntary association.

Perhaps the most compelling observation I can make about the nature of the Huntington Society of Canada is to quote your co-founder and Executive Director Ralph Walker. Mr. Walker has noted quite rightly that society is made up of "ordinary people doing extraordinary things."

Today, I take great pleasure in saluting the extraordinary efforts of

each and every one of your 1,500 volunteers across the country.

I wish you a productive and rewarding final two days to your workshop ... and continued success in the years ahead.

Thank you.



Speech / Discours

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Speaking Notes
for
The Honourable Diane Marleau
Minister of Health

The Canadian Institute Conference
on
Health Care Institutions in Canada
Toronto, October 23, 1995



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51/95

Thank you for your warm welcome.

I was very pleased to receive an invitation to address you today.

The Canadian Institute is recognized as a national leader in professional development and continuing education. We are now in an era in which no one can afford to stop actively seeking out new areas of knowledge, and better ways of doing things. Your symposiums are known to be among the best in providing information that helps keep Canada on the leading edge.

Today, you are proving once again that your reputation is well-deserved. You have brought together some of the best minds in the country to address the challenges that confront the health care system, and how we can go about meeting them.

Moreover, you recognize that health care is an economic concern. Indeed, how we manage our health system is one of the most important economic issues Canadians face.

The health of the Canadian people is vital to the health of the Canadian economy. And the health of the Canadian economy is vital to the health of our people.

Economic analysis makes it clear that Canada's health system provides major economic benefits. These benefits stem from efficiencies and cost-savings associated with public funding. Our health system attracts investment to Canada -- and it helps business to compete from Canada.

It is easy to see why. Since we are in southern Ontario, all we have to do is look at the auto industry. For every car that rolls off the assembly lines in Detroit, the cost includes an average of more than \$700 (U.S.) for privately funded health insurance. Is it any wonder that the Big Three automakers have consistently been among the strongest voices for a comprehensive public health insurance plan in the United States?

Our public health insurance system is a major asset to business. But it isn't a subsidy. It's an efficiency. We have entered an era when the public sector's role is, quite appropriately, being re-examined. Valid questions are being asked about government's place, and the values of public funding versus private funding. But health care is one area where government is not just as efficient -- it is more efficient.

Our Medicare system is based on sound economic principles -- the same kind investors look for in evaluating a private sector enterprise.

First, our publicly-funded system has enormous economies of scale. We have only one insurer in each province that provides standard health insurance coverage of all residents. No risk rating is needed. Payments to providers are simple. Financing the system is streamlined.

Second, our system results in lower overhead costs. Researchers at Harvard University have found that in Canada we spend only 1.1 per cent of Gross Domestic Product on health-care administration. The United States -- with its private health insurance schemes -- spends about two and a half times that much. If we spent as much as the Americans do on administration, health care expenditures in Canada would increase by \$18.5 billion per year. That's more than the entire health-care budget for Canada's largest province.

Third, a publicly-financed system can ensure universal coverage. That is an important element to a healthy workforce, which contributes to a more competitive economy and economic growth. When there are fewer work days lost to illness, productivity increases. Healthier people make fewer demands of the system, they live longer and they contribute more to the overall wealth of the nation.

Universal coverage is much more difficult, if not impossible, in a system based on private insurance schemes. We have evidence of that in the United States, where fully 15 per cent of Americans are without any health insurance.

The fourth factor that makes public health insurance systems more efficient is government's tremendous bargaining power in negotiating the costs of services, by setting and enforcing global budgets for hospitals and physicians' fees. This gives government powerful levers to keep health care costs under control.

And we are using those levers. For proof, all you have to do is look at the numbers.

Canada and the United States used to have similar health insurance schemes. We also had comparable rates of health spending -- approximately 7.5 per cent of Gross Domestic Product. But since Canada's national health insurance plan was fully implemented in 1972, our rate of spending has grown at a much slower pace than that of the Americans.

By 1994, the U.S. per capita spending on health care more than doubled to more than 14 per cent of Gross Domestic Product. Here in Canada, we spent about 9.7 per cent.

In fact, real per capita public health expenditures in this country have been declining since 1993. Preliminary estimates for 1994 suggest public spending on health declined in real terms by about 3.4 per cent.

Enormous economies of scale, low overhead costs, improved worker productivity, tremendous bargaining power, and proven results. If you heard about a private company that could point to these attributes you would be rushing off to call your broker.

These are just some of the special characteristics of publicly-funded health care that make government involvement not only desirable, but necessary. You just have to look at the Canadian record to see that it works, and works well. What other business can boast of a customer base comprising all Canadians, with service providers and facilities from coast to coast, that has been in service for over 25 years, that has an enviable international reputation, and satisfaction rating usually in the neighbourhood of 80 to 90 per cent?

It is not by accident the United Nations rates Canada number one on the human development index. It has taken effort, and the development of the Medicare system has been an important part of that.

And it is not surprising that an Environics survey in late 1993 concluded 79 per cent of Canadians believe it is very important for the federal government to sustain the health system.

For us, the key lever for doing that is the *Canada Health Act*. It ensures that the positive aspects of our health system that I have described remain firmly in place.

The federal government has a responsibility to ensure that the provisions of the *Canada Health Act* are fully enforced. We assume that responsibility when we transfer federal dollars to the provinces. And the amount we transfer is considerable.

Let me set the record straight on that, because there has been some suggestion that the federal government's funding role is becoming a minimal one.

This fiscal year, the federal government is transferring \$15.5 billion to the provinces and territories for health services. Total federal health, post-secondary education and social contributions for 1995-1996 will be about \$29.7 billion under Established Programs Financing and the Canada Assistance Plan.

With the introduction of the Canada Health and Social Transfer, in 1996-1997, total transfers will be \$26.9 billion.

The transfer reduction for 96-97 represents less than 3 per cent of estimated provincial-territorial expenditures for health, post-secondary education and social programs. It is less than 2 per cent of provincial government revenues.

What is important to highlight is that federal cash contributions under the Canada Health and Social Transfer will not disappear. In fact, when you take into account the economies that provincial governments are putting in place, the federal proportion of funding in most provinces will remain steady, and in some it may even increase.

Make no mistake about it, the federal government is in Medicare to stay. There will be stable, ongoing cash in the system to ensure it is sustained.

But sustaining the health system does not mean spending more. It means spending better. Research demonstrates there is no direct relationship between increased health spending and improved health outcomes. It is not the *amount* of money we dedicate to health care that will assure a healthy population. Rather, it is the *way* we spend it.

To quote Judith Maxwell in "Sustainable Health Care for Canada":

"Much can be done to make the health system more efficient without adversely affecting the public's health. The secret is to substitute less costly types of delivery and forms of treatment in more appropriate care settings."

We can do more with less, without in any way jeopardizing universal access to quality health care, on uniform terms and conditions for all residents of Canada. In fact, we are doing more with less, as comparisons with the United States demonstrate.

To continue to do that, we have to build on what works -- we have to build on the foundation of a publicly funded system. It has demonstrated its efficiency; it has proven results.

But while real per capita public health expenditures have been declining since 1993, private health expenditures have been *going up* -- at a real rate of over two per cent since 1992.

Traditionally, the split between public and private spending has been about 75-25. Currently, the private share is rising and is now over 28 per cent. This is a trend that must be examined as we look at ways to keep health care affordable for all residents.

This leads me to the debate over facility fees for medically necessary services at private clinics. Such fees are a clear violation of the *Canada Health Act*, which is central to Medicare and the economic and social benefits it has generated.

A week ago, we reached my October 15th deadline to eliminate such fees. I have stood firm by my deadline. As of October 15, provinces not adhering to the Canada Health Act will face dollar-for-dollar deductions from their federal transfer payments.

We are doing this for several reasons. One of the most important is the threat that facility fees pose to the public system's ability to continue to deliver the efficient results we have come to expect.

By billing both their patients and the taxpayers, private clinics don't take pressure off the system. They take resources away from the system. Facility fees fracture a system whose greatest strength is its cohesion.

Just look at the issue from the point of view of efficiency and economies.

Encouraging the growth of private clinics with partial public funding takes all of the strengths and efficiencies of our health system and turns them on their head.

It reduces economies of scale.

It undermines bargaining power.

Like the U.S. system, a movement toward publicly-funded private clinics could shift more of the Canadian economy's resources to health care -- at the expense of other areas that could provide greater benefit to the health of Canadians. It could very well end up costing more while providing less. It would be hard to think of a better example of counterproductivity.

Moreover, it threatens to create an undersupply of services to the majority of Canadians -- and an *oversupply* to a wealthier minority. It would be difficult to think of a better definition of inefficiency.

Medicare is based on fundamental principles. But they are not abstract principles. They are pragmatic. They were designed to make it possible to provide every Canadian with the level of health care he or she truly needs. But we must do so at a cost we can genuinely afford.

We can do that -- and we can do it efficiently. Medicare has demonstrated that.

There is no doubt that we are in a period of dramatic transformation. Demographic shifts, technological breakthroughs, and diminishing financial resources have all combined to put increasing pressure on our ability to maintain the quality health care that is integral to our economy and to our society.

We can meet these pressures. We can meet them by continuing to base our strategy on public health care -- a strategy that has already proven itself.

The challenges facing us in health care are the shared responsibility of all Canadians. The federal government is prepared to lead. But we are looking to business and community leaders like you for support, because our national health system belongs to each and every one of us.

Each of you can bring ideas, experience and expertise to the dialogue. Together, we can enhance the efforts of governments at all levels to successfully respond to the complex problems facing this country's health system. I hope that I can count on you to work with me, as we do just that.

Thank you.



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Speech / Discours

Speaking Notes
for the
Honourable Diane Marleau
Minister of Health

Second Conference
of the
Canadian Society for International Health
Ottawa, November 12, 1995



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Canada

Good afternoon. I want to thank the Canadian Society for International Health for its invitation to participate in this conference, and the Canadian University Consortium for Health in Development for helping to make the event so successful.

This symposium provides a practical opportunity to exchange ideas about ways to renew the world's health systems in order to ensure that they are sustainable and that they reduce health inequalities among our citizens.

Nowhere is the need to reduce inequalities more apparent than when you look at the way women's health needs are addressed in all parts of the world.

I want to talk more about women's health needs. But first, I want to discuss how nations are working together in the area of health, and the approach we are taking in Canada.

The increasing globalization of health issues and the resurfacing of infectious and transmissible diseases have re-emphasized our interdependence on international health information and expertise.

Disease knows no borders. Fortunately, the information, experience and education needed to combat disease are limited less and less by borders each passing year.

In this regard, Health Canada is pleased to work closely with other countries in a number of ways:

- ◆ Working with foreign governments and international health organizations to improve our surveillance networks and alert us to potential epidemics.
- ◆ Pursuing joint prevention strategies such as the Country-Wide Integrated Non-Communicable Diseases Initiative.
- ◆ Sharing our expertise in major health promotion campaigns such as the international component of our Tobacco Demand Reduction Strategy.

Our work with both developing and developed countries, and with international bodies such as the World Health Organization and the Pan American Health Organization, allows us to benefit from each other's experiences and to make the best use of severely stretched health resources.

No matter what corner of the globe we occupy, governments everywhere are grappling with better ways to provide quality health care in a cost-effective way.

Diminishing financial resources, demographic shifts, and technological breakthroughs have all combined to put increasing pressure on our ability to maintain the quality health care that is integral to society.

For all our similarities, each country's health system is unique. It is a vital social institution that reflects the values, history and priorities of the society it serves.

In Canada, we take great pride in our system -- one that is universal, portable, comprehensive, accessible, and publicly administered.

Indeed, we believe our health system -- and the values it enshrines -- are constitutive of our identity as Canadians.

Health renewal is well underway in this country. Increasingly, we are addressing all of the factors -- human biology, education, the social, economic and physical environments, lifestyles and health services -- and how they inter-relate on an individual's well-being.

Using legislation, education and promotion, we are changing people's attitudes and actions to reduce tobacco use, decrease chronic diseases and encourage healthier, more satisfying lifestyles for Canadians.

We are shifting away from hospital-based medicine and moving towards community care. We are strengthening working relationships among community health workers. We are encouraging and supporting consumers to participate in decision-making regarding their health and health care. We want them to be aware of the risks and responsibilities. And we are constantly searching for more integrated approaches to health that go beyond health care alone.

Many of these changes are lessons we have learned from developing countries, where fostering local and community health care have resulted in better and more efficient health delivery.

What is most encouraging is that we are discovering that these measures, designed to better manage our health resources, are resulting in improved health for Canadians. We are learning that it is the quality, not the quantity, of care that counts most.

And we remain committed to the principle of equality. That is the ideal. We do not want a health system that is loaded for or against any group. What counts is how sick you are, not how much money you have. It is what you need, and why you need it. We are determined to meet those needs, to the best of our ability.

That brings me to the subject of women's health.

Conventional approaches to health care and treatment have often been found inadequate for the women of this country -- like those the world over.

Certain natural life processes have been the subject of excessive medical treatment -- menopause, fertility and childbirth for example. And not always to the benefit of women and society. We have been working to change that.

Women experience systemic discrimination on the basis of race, social standing, disability, sexual orientation or age -- factors that diminish health.

Canadian women are poorer than Canadian men, and there is a clear link between poverty and poor health. Although women in Canada outlive men by an average of seven years, they experience more chronic disease and disability than men do. Longer life must not let us give up the pursuit of a better quality of life.

Diseases exclusive to women have been largely ignored by the scientific establishment. Particular attention is necessary for certain demographic groups, such as women with disabilities, women from culturally diverse communities, immigrant women, native women, senior women and adolescent girls.

We must respond to the health needs of the population. That is why a focus of our renewal efforts entails a gender-specific approach to research, public education programs and global health policies.

That is why we have established a Women's Health Bureau to advance the health needs and concerns of Canadian women within the Canadian health system - emphasizing the gender, social, cultural and economic factors which affect health.

That is why we are in the process of establishing a national network of Centres of Excellence for Women's Health which will work to ensure effective and equal treatment of women's health issues within the Canadian health system.

But just as the problems in women's health are not confined within borders, we cannot so restrict our search for solutions. In countries that want to move ahead socially and economically, women's health cannot be ignored.

That is the message Canada took to the recent Fourth World Conference on Women in Beijing and last year's International Conference on Population Development in Cairo.

At Beijing, we joined with over 170 nations in adopting the Platform for Action to accelerate progress towards equality between women and men. Women's health is one of the 12 critical areas of concern that was identified. Now we must all work to advance both our domestic and international agenda on women's health issues, and bring that agenda to life.

There is much we can all do together, but the health challenges facing women in developed countries are dramatically different from those facing women in developing ones. Working beyond borders starts by working beyond the borders closest to you.

There is much we in Canada can do to promote the health of Canadian women by exchanging views and information with other developed countries. Today, we are prepared to take an important step in that direction jointly with the United States.

I am very pleased to announce that next March, U.S. Secretary of Health and Human Services Donna Shalala and myself will co-sponsor the first **Canada - USA Women's Health Forum** to be held in Ottawa.

While our two countries have different health systems, many of the issues that affect women are common to both our countries. Issues such as health conditions and diseases affecting women, environmental and occupational health, violence against women, research focusing on women's health concerns, and how bio-medical cultural and economic factors -- including gender -- influence women's overall health.

The Forum will be an opportunity for Canadians and Americans to share information on key women's health issues, to learn from each other and identify areas of common interest where joint initiatives could be considered.

Policy makers, researchers, health professionals, academics, community

workers and consumers will examine our respective programs and policies, and highlight the opportunities for mutual advancement of women's health.

I am convinced that, by working together, we have a better chance of meeting the many health challenges that confront our countries today and that will only increase in the years to come.

It has been said that the best way to predict the future is to create it. I think that is precisely what health renewal is all about. It is about leading, rather than being led by circumstances seemingly beyond our control.

In Canada, we are convinced we can meet the demands of the future by building on the foundations of the past. We believe that only by renewing our commitment to universal health care can we enhance the quality of life for all our citizens.

When Ralph Nader was in Ottawa recently for *National Medicare Week*, he said: "Even with your problems, you have the best health care system in the world. It's universal, it's more compassionate, and it has far less red tape..."

Medicare is our assurance that we will continue to have a system that is "universal, compassionate, and with far less red tape." A system that is committed to people. A system that is based on equity.

If the challenges confronting health systems in Canada and the international community are great, this conference offers proof that the will to overcome them has never been greater. I have every confidence we can meet them by bringing our ideas, experience and expertise to the debate.

Thank you.



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Speech / Discours

Speaking Notes
for
The Honourable Diane Marleau
Minister of Health

Official Opening of
The Seniors' Information Office
Elliot Lake, November 14, 1995



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58/95

Thank-you, Brent, for your kind introduction.

It is a pleasure to be with you today to share in your celebration of the opening of the Seniors Information Office here in Elliot Lake.

It is gratifying to see so many members of the community -- seniors, and those not there yet -- here to celebrate the success of this innovative and effective community program.

You have a unique partnership here in Elliot Lake. Firstly, you took a **vision** of linking retirement living with economic development, and then you harnessed the **collective efforts** of the community to make this vision a reality.

Your collaborative efforts are a model for all Canadian communities striving to create a better future for their citizens. Most importantly, your efforts highlight the positive social and economic contributions seniors can make -- both individually and collectively -- to revitalizing communities.

I want to acknowledge the invaluable work of **Elliot Lake Retirement Living Incorporated** in developing this collaborative vision, and for working so hard to bring town services, voluntary organizations and seniors together.

Community support programs to establish and achieve common goals is a cornerstone of my Department's activities for seniors. I am pleased that Health Canada was able to provide initial funding support, as well as \$325,000 over three years to support the Elliot Lake Seniors' Information Office -- which I will have the honour of officially opening later this afternoon.

Our federal government's funding through **New Horizons: Partners in Aging Program**, will assist the Seniors' Information Office in responding to the special needs of seniors in your community.

Since the early 1990s, there has been an influx of seniors in Elliot Lake. The seniors population of the town has grown from three percent to 28 percent of the total population.

Moving to a new community can mean a loss of previous support systems and networks. For **seniors at risk** -- those whose health, well-being and independence are threatened by the situations or conditions in which they live -- the move to a new community can be traumatic. It can accentuate difficulties such as loneliness, grief, health problems, decreased mobility, and vulnerability.

The **prevention/intervention role** of the Seniors' Information Office helps seniors resolve these problems by emphasizing collective action and mutual support. For seniors who find themselves in situations of risk, the outreach offered through the Seniors' Information Office -- in conjunction with Elliot Lake Police Services -- is particularly important.

Health Canada has adopted a number of proactive strategies to foster community partnership programs for seniors to prevent at-risk situations and promote good health.

The **New Horizons: Partners in Aging Program** and its predecessors have been very successful. They have produced community-based initiatives and activities for seniors to enable them to remain **active members** of their communities.

Canadian seniors built this country. Your children have continued this process into the present technological age. Seniors want to be treated as equals, to have their views taken into account, to be listened to, and consulted on issues affecting them. Why shouldn't seniors participate directly in the design and implementation of programs touching their lives?

At the heart of our collective efforts with and for seniors is our goal of helping older adult residents in our communities live healthier, more independent and more productive lives.

Seniors have told us that independence, meaning freedom to do what they want to do, responsibility for their own lives, and control over daily living conditions, is very important to them.

The seniors here today prove that the vast majority of older Canadians are healthy and they live independently. Figures show that most seniors continue to participate in social and economic activities well beyond retirement. They earn incomes, spend money, vote and take an interest in society.

Seniors contribute significantly to the Canadian economy. Most own their own homes and are mortgage free. In terms of financial independence, statistics show that only 34 percent of families headed by a senior report any indebtedness. This compares to 73 percent of all Canadian families report to having some form of debt.

It has been said that Canadian seniors are the largest peer support group in the country: many contribute to charitable organizations which help seniors less fortunate than themselves. Seniors give a lot to their communities. Nowhere is this more evident than here in Elliot Lake.

The Supportive Seniors Programs and the Seniors Information Office empower seniors to take greater control of their lives by helping them to maintain and improve all aspects of their physical and mental health.

I congratulate all of you in Elliot Lake for your impressive efforts to support seniors and to promote seniors' independence within the community. With the strong foundation you have built, I am confident you will enjoy further success in the years ahead.

Thank-you.



Health
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Speech / Discours

Speaking Notes
for
The Honourable David Dingwall
Minister of Health

Institute for International Research Conference
The Toronto Hilton Hotel
Toronto, April 1, 1996



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09/96

Canada

Thank you very much for your kind and eloquent introduction. My challenges as the Minister of Health and those of my provincial colleagues go beyond health care or Medicare; they include population health as well. Population health cuts across many areas of government at every level, regardless of jurisdiction, as well as other sectors of the economy. And it is through collaboration and cooperation among the various partners and stakeholders, that we can improve not only health care, but the health of all Canadians.

That is why I have come to this portfolio with a clear mandate from the Prime Minister, to try to work with provincial and territorial governments, stakeholders at the national and regional levels, and individual Canadians. We all share a common objective. I believe our objective -- as federal and provincial/territorial ministers of health, as well as stakeholders in the health care system -- is to improve the quality of health in this country. I don't think Canadians want to see government fighting government; they want to see us fighting the various problems which confront Canadians.

In that regard, I think it important that I acknowledge, once more, some of the modernization that is taking place in the various provincial health care systems throughout the country. All too often, we are tempted to criticize them for their actions, but in fact, most, if not all, provincial and territorial projects have been undertaken to improve the quality of health care in their respective provinces.

You know, in partnership and dialogue with the provinces, it is clear that we at the federal level had to provide some degree of stability regarding financing. That is why the recent budget on March 6 went a long way toward providing provincial/territorial governments with some degree of consistency in funding health and other social services in this country: \$25.1 billion each year over a five-year period -- comprising a tax floor, requested by the provinces -- and tax transfer points. That is very important because the provinces, which deliver health services, need some measure of consistency and stable funding from the federal government. I was very pleased to be a part of a federal government that seized that opportunity to provide that kind of support for our national health system.

A second priority for me at the federal level, is to ensure that there is universal access to health care in every province, in every region of Canada. I will debate the principles of the *Canada Health Act* anywhere, but the principles of the *Canada Health Act* are not negotiable. And the reason why they are not negotiable is because Canadians have said over and over and over again, that they support those five basic principles.

When we talk about universal access, we refer to access to medically necessary services which are provided by physicians and hospitals across this country. If you were to look at any graph or social economic criteria, you would find that Canadians, by and large, have no difficulties accessing various physicians. They are not barred because of their income. But, if you do the same for non-insured medical services, you would find a great disparity.

One of the first disparities that comes to mind is dental services. Those who have sufficient incomes, have sufficient access. Those who do not have that kind of income do not have access. We will be vigilant in enforcing the principles of the *Canada Health Act*, and I am confident that with the resolve of the provinces and territories, the stakeholders and Canadians alike, we can get on to providing quality care for all Canadians.

There is much to be said about health prevention and health promotion in this country. Health determinants, whether they be in the area of nutrition, or fitness and obesity -- which plagues large parts of our society -- are important elements when talking about improving the health of Canadians. I don't think I have to remind this gathering that environmental health is another area where we are seeing phenomenal growth. This has substantial impact on day-to-day care, both in terms of delivery, and also in terms of population health.

These are all areas that we, as a federal government, wish to pursue. We will not pursue them unilaterally, of course. We want to discuss them collectively with provinces, stakeholders and interest groups, members of the private sector, as well as non-profit organizations across this country. Because, in my view, if we can make some real inroads on these areas, it will have a substantial impact not only on the quality of care of individuals, but also in terms of the costs which are associated with health care.

The next point I would like to raise with you very briefly, is the issue of tobacco. Tobacco is a major issue. But I have particular restrictions to deal with: a decision of the Supreme Court of Canada. The Supreme Court of Canada affirmed that smoking consumption in this country causes death -- at least 40,000 deaths per year.

There is a responsibility, if not a fiduciary obligation, on the part of the federal government to move forward with a plan of action to address that fundamental problem. I am appalled, as the Minister of Health, to see the number of young people who smoke, in particular, young women.

I have to work with my provincial counterparts and stakeholders to bring forward a comprehensive, focused package to address that particular issue. And let there be no misunderstanding, smoking is a costly exercise to the Canadian economy -- \$11 billion per year -- in terms of its cost to the health care system and the overall loss of productivity for Canadians as a whole.

Another issue of concern to me is women's health. I think I can say, with perhaps more objectivity than most, that "women's health" has been a rhetorical expression for politicians at election time. Women are the biggest users of the health care system. I find it passing strange that we have talked a lot but delivered little related to women's health in this country. I have said to Health Canada officials, this is now a priority. Let us start to move. I will soon be announcing the creation of Centres of Excellence for Women's Health. But first, I want to be certain that these centres are going to be able to produce real deliverables. Yes, I want them to assist and to facilitate the networking, but I think we have to have results, particularly if the Government of Canada is going to be spending your taxpayers' dollar.

In August, I will be hosting a Canada-U.S. forum with the U.S. Secretary of Health, Donna Shalala. The Forum will examine a variety of concerns: breast cancer, cardiovascular diseases, fitness, obesity, the misuse of prescription drugs, and substance abuse -- a whole host of issues which have a profound and immediate effect on women in this country.

I will also be proceeding with legislation on new reproductive technologies. I want to consult with provincial and territorial governments. Discussions are taking place, as I speak, regarding the format in which we wish to frame the terms of a new federal statute.

Some of you who may have followed this particular issue will recall that the previous administration sponsored a Royal Commission on New Reproductive Technologies which contained numerous recommendations. I hope to soon be able to move on a number of those in a substantive way.

Women's health is an important priority for the Government of Canada, as I am sure it is for provincial governments and stakeholders alike. It is time for us to move from words to an action plan to address the key issues surrounding women's health.

The issues of aboriginal health are also profoundly important for the country and we cannot just slide them off the table.

There are issues affecting children, in terms of their diet as they go to kindergarten, as they go into school, that are phenomenally important to this country, that we, as a national government, want to address.

What about the issues of seniors and elder abuse and palliative care? You know, "palliative care" is a phrase that often makes people uncomfortable. When you talk about palliative care with ordinary Canadians, even those involved in the health care professions, they get a little bit nervous, they start to move and shift around. Palliative care means talking about death, and people are not very comfortable with that.

It is not something that people want to talk about. But death is a very natural thing. Governments across this country should consider seriously how we handle this particular issue, how we develop the infrastructure to help those who are dying.

I read June Caldwell's wonderful book about how a community came together to help a friend who was dying. I am not talking about large sums of new public money; I am talking about how we manage our system better. I wish to work co-operatively with provinces and stakeholders on this issue.

There are two other issues that I wish discuss: drugs and research. Many of you will know that Parliament will be reviewing Bill C91 in 1997. It will be an opportunity for many of you, provincial/territorial governments and a host of Canadians to make representations and interventions as to how well the pharmaceutical system is, or is not, working.

But, let us be clear here. The Patented Medicine Prices Review Board, which reports to me, has done a pretty effective job of ensuring that prices for patented drugs have not risen more than the Consumer Price Index. That should be acknowledged. I must say that I am not as optimistic about the amount of money that the brand name companies signed on for the purpose of academic research. I am being told by my senior advisors, particularly at the Medical Research Council, that there is a long way to go. The undertaking for this MRC-PMAC Health Partnership was \$200 million over five years. We are now just at the \$45 million mark. We will have to review this well before 1997.

Now, generic brand companies also have a role to play in this economy. Certain regulatory restrictions have been placed on them, which we at the federal level are currently examining. But, you know, the cost of medication in this country is growing at a phenomenal rate. It is one of the cost drivers for the provincial health delivery systems in this country and provincial governments will want to look at it. The Minister from Saskatchewan, who is here with us this morning, has already written to me about Bill C91 and the cost he has incurred as the Minister of Health in that province.

But, we are not only going to look at costs. I want to work with the provinces and territories on the usage of drugs in this country, which, I am told, increases about 15 percent on an annual basis. Even at ten percent, that is a phenomenal increase in the usage of prescription drugs.

Everywhere you go you can see signs of abuse. I want to raise this issue with my provincial colleagues and see if there are ways in which we can help one another in terms of both cost and usage. It is also going to require the co-operation of the Canadian Medical Association. Other countries have attempted to do it, some of them successfully, some of them not all that well. Perhaps we, as a nation, working cooperatively with the provincial and territorial governments, would be able to examine what works and what doesn't.

We need to embark upon an action plan -- not rhetoric or words of concern -- to eradicate this major issue.

We in Canada are blessed with a large number of highly qualified scientists. The Medical Research Council of Canada, the National Forum on Health, the Health Services Research Fund, which was announced in the March 6 budget, the research that we are doing on HIV and AIDS, Alzheimer's and cancer, the National Health Research and Development Program: these federal programs are essential to those in the research field.

I have said to the President of the Medical Research Council that I want the Council to take a much more aggressive approach to research in this country, not only domestically but internationally. I want it to partner with the private sector. I want it to work with provincial governments and various organizations to look at ways we can sell not only Canadian technology, but also the results of our various studies and research.

We have to find better vehicles to communicate the results of our research to Canadians. It is no good to accumulate volumes and volumes of information if it sits on the desk of some bureaucrat in downtown Ottawa. It has to be shared with people who can use it.

In the introductory remarks this morning, we heard about health care, its future and the challenges we face. There are challenges in Medicare. There are challenges in terms of population health. But I am confident that, with the right resolve by all of the players, we can successfully attain our goal.

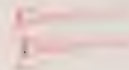
I came here this morning to reaffirm a cause and that cause is good health. It is the cause of stakeholders, of provincial, territorial and federal governments, of health care professionals and Canadians from coast to coast. In that regard, I am reminded of the words of Tennyson when he said, "I am a part of all that I have met ... tho' much is taken, much abides ... That which we are, we are. One equal temper of heroic hearts ... strong in will to strive, to seek, to find and not to yield."

My friends, I share with you: The Government of Canada will not yield, will not yield in our resolve to improve the quality of health care in this country and the health of all Canadians. Thank you very much.



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Speech / Discours

SPEAKING NOTES
FOR
THE HONOURABLE DAVID DINGWALL
MINISTER OF HEALTH

CANADA

TO THE 49TH WORLD HEALTH ASSEMBLY
ON
FIGHTING DISEASE AND FOSTERING DEVELOPMENT
GENEVA, May 21, 1996



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Canada

Mr. Chairman, fellow ministers and delegates, Ambassadors, ladies and gentlemen:

We live in a world that is capable of exploring outer space and of probing the very nature of matter and life, yet we seem to have little interest in addressing the stark realities of human vulnerability. The information contained in this year's *World Health Report* is indeed a cause for concern. One third of all deaths each year worldwide are due to infectious diseases, yet as the report tells us, most of these deaths are preventable.

I believe that collectively, we can and we must do better. We must find ways to offer Member States and their citizens greater protection against infectious diseases.

In Canada, we have concluded that we can do more to protect Canadians against infectious diseases.

Other solutions, however, can only be found through international cooperation. Reports such as the one we are examining today are not only sobering, they are demonstrable evidence of the continuing need for a vital and dynamic World Health Organization.

Canada will build upon its tradition of supporting international action for health this July when it hosts the XI International Conference on AIDS in Vancouver. The integration of global research and applied knowledge at this Conference will afford all delegates significant opportunities to learn, to share, and to help advance our common understanding of HIV/AIDS.

Less than two years from now, Member States will be invited to endorse a new global health policy, including a redefinition of the World Health Organization's role and mission.

We have in Canada seriously reflected on the elements that should characterize the World Health Organization of tomorrow.

Firstly, we believe that as a specialized intergovernmental organization, the World Health Organization should endeavour to find common solutions to the collective problems of its Member States.

Secondly, the Organization's normative functions need to be clarified, strengthened and in some cases expanded to address strategically focused areas.

Thirdly, this Organization, in a spirit of equity and solidarity, has decided that health development in each Member State is a collective responsibility. This is a commendable principle, but we must ask what it means in practice. What should the role of the Organization be in national health development?

Fourthly, we believe that in addition to helping Member States make the best use of international health norms and standards, the World Health Organization should offer specialized technical cooperation to its Member States. We also believe that this cooperation should be offered within a limited range of priority areas where the World Health Organization is recognized as having the capacity to deliver.

Mr. Chairman, the World Health Organization has had great successes. The eradication of smallpox and virtual elimination of polio have changed our world for the better.

Canada is concerned, however, that the World Health Organization seems in recent years to have lost its momentum and its place as the primary reference point for health issues within the international system. Its star has dimmed.

I do not want to dwell on the past, however, in the words of a great American President (John F. Kennedy), "our task is not to fix the blame for the past, but to set the course for the future."

Canada intends to work with the World Health Organization and other Member States to set that course.

We are under no illusion that it will be an easy task, but I believe it is necessary.

The objectives we seek are as follows:

The World Health Organization of the future must be routed in effective programming and these programs must focus on priority areas. The programs must meet the real needs of Member States and must fall within the capacity and capability of the World Health Organization. For Canada, these priorities are new and emerging diseases, AIDS and reproductive health, and tobacco control measures.

As a second element, we believe the programs of the World Health Organization must be based on a strengthened, effective and fully transparent management. Good management is a valued asset and is particularly essential for public institutions which are holders of the public trust, such as governments or international organizations.

We also believe that the World Health Organization must operate within an international system where overlap and duplication are eliminated. These phenomena must bring disrepute to the international community and waste the resources of all governments. They must be eliminated. We hope the World Health Organization will show leadership to the international community in this regard.

And finally, it is important to all of us that the World Health Organization of the future operate in a way that recognizes fiscal realities in a responsible and positive way. Fiscal responsibility can be a liberating force if it is managed effectively.

Mr. Chairman, these are major challenges for any organization. We believe the World Health Organization can and will meet them if we are to sustain and improve on the health gains we have collectively and individually achieved.

The World Health Organization was once the shining star of the United Nations system. Our goal is no less to restore and enhance the brightness of that star in the hope that its light will lead us all to a better world and a brighter future.

Thank you.



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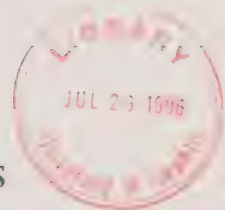
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Speech / Discours

Speaking Notes
for
The Honourable David C. Dingwall
Minister of Health

Opening Ceremonies

XI International Conference on AIDS
Vancouver, British Columbia
July 7, 1996



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20/96

Canada

Distinguished guests, conference organizers, I would first like to recognize the participation of people living with HIV and AIDS and welcome you to this conference.

We are joined by researchers, frontline workers, health and social services providers, family and friends from every corner of the globe. Welcome to Canada and this Eleventh International Conference on AIDS.

I am proud to be here on behalf of the government of Canada to stand in solidarity with all the citizens of the world in the struggle to put an end to this devastating disease.

The HIV/AIDS disease has presented the human family with one of its greatest and most difficult challenges.

Our presence here today is unmistakable proof that the human family is fighting back, that we are going to continue to fight back, and that someday, by working together — we are going to win!

We all owe a debt of gratitude to the conference organizers for their exceptional efforts. This is the largest meeting ever held on this issue and it is one that brings with it a renewed sense of hope that we are making steady progress toward solutions.

Canada is very proud of the role the HIV/AIDS community has played in our country to improve the quality of life of those affected by this disease.

We are particularly proud of our own Canadian heroes in the fight against AIDS — the doctors, nurses, educators and scientists who are at the forefront of research, prevention and care efforts here in Canada and around the world.

The recent development by Canadian researchers of 3TC — which is helping to improve the quality of life of people living with HIV/AIDS — is a source of great satisfaction to us, and we salute all those involved in its discovery.

Each new discovery, each new finding, restores our hope that some day we will be able to end the anger, the fear, the frustration and the pain of those who suffer its devastating consequences.

People living with AIDS deserve compassion. They deserve respect and they deserve our help.

As former Prime Minister Pierre Elliot Trudeau wrote 15 years ago in *Dangers and*

Options: The Matter of World Survival: "Interdependence is the dominant fact of life in our era -- that we are all responsible for each other's well-being, and we must learn to live together or face the prospect of perishing together."

Which brings me to something I have been waiting to say for some time now.

In our continuing concern for people living today with HIV and AIDS, I urge you to remember those thousands of people in many different countries who received HIV-infected blood and blood products during the late 1970's and early 1980's.

HIV transmitted through the blood supply caused a public health catastrophe which could not have seemed possible to those public health professionals.

HIV shocked blood systems around the world. It left thousands of people dead, or facing the agonizing prospect of living with AIDS. It left a painful legacy of illness, financial devastation and emotional despair for their families and loved ones.

And it gave rise to bitterness, anger, and a feeling of betrayal that blood -- something which for so many years had been a miraculous therapeutic gift of life and hope to those in need -- could be the cause of so much harm. Today, I want to tell my fellow citizens who have been so devastated by the impact of HIV/AIDS how deeply I regret the tragedy that has forever changed their lives.

I want to tell you how deeply moved I have been by the stories of people infected by blood and blood products and of my sorrow for those who are suffering through the loss of friends and family members.

Much as we want to, we cannot change the past. But we can work to prevent similar tragedies in the future. We can continue to show compassion for those who are living with the results, we can work to understand what happened and help restore public trust in our blood supply system.

In Canada, governments agreed to a joint expression of our collective commitment to resolve problems with Canada's blood system and to restore confidence in what we agree is a fundamental component of our health care system.

Will these actions be enough to heal all the hurts, and erase the suffering?

No. Of course not.

But it is an expression of caring and a commitment to find solutions, and it is made

with good faith and sincere intentions.

The Canadian government continues to put much of its effort into finding better ways to prevent the spread of the disease through education and awareness -- particularly among young people and those involved in high risk activities.

And all of us around the world must continue to focus our research resources on finding a vaccine for HIV and a cure for AIDS.

We welcome all representatives of developing nations to this conference. We recognize the enormous challenges confronting your nations as 80 percent of all those who are infected live in the developing world.

It is also our intention to encourage the private sector to get more vigorously involved in addressing the HIV/AIDS crisis. It is not simply a health issue. It is also a human rights issue, and an economic issue.

The national and international business communities increasingly understand that they need to come to terms with this disease.

They too have an important leadership role to play in helping employees deal with the issue, and in getting involved with financial support for research, care and treatment.

It is for all these reasons that I believe the theme of this conference could not be more appropriate -- "**One World, One Hope**".

The world is relying on each and everyone of us.

So, welcome to Canada. May our deliberations send a message of real progress and real hope to all the peoples of the world.

Thank you.



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Speech / Discours

Speaking Notes
for
The Honourable David C. Dingwall
Minister of Health

Opening Session
of the
Canada/U.S./Mexico Satellite Symposia
on
Innovative Partnerships in Education and Care

XI International Conference on AIDS
Vancouver, British Columbia
July 8, 1996



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21/96

Canada

Thank you. Dr. O'Shaughnessy, Secretary Shalala, Professor de la Fuente, symposia participants and guests: I am honoured to take part in this opening session of a discussion that I believe is central to the way we approach the issue of HIV/AIDS.

I am pleased that we have united in this joint, three-nation effort with Mexico and the United States to bring together providers of health and social services with people living with HIV/AIDS.

I believe that Secretary Shalala and Secretary de la Fuente will agree that this disease is clearly as much a priority health issue for their governments as it is for the government of Canada.

The goal we share is not only to continue to help in the search for a cure, but to improve the quality of life of persons living with HIV/AIDS throughout North America and around the world.

Indeed, our compassion as societies can be measured by how we treat people infected with HIV disease, and the kinds of support we offer them, their families and their caregivers.

As we share our experiences and knowledge, I hope we can also look at developing new models that can be made to work in other communities, other regions and other countries.

In Canada, we have seen some remarkable developments in the way care, treatment and support is provided to persons living with the disease. Not the least of those is that persons living with HIV/AIDS are now more actively involved in determining their own treatments, something which has been supported in Canada's **National AIDS Strategy**.

Developing a more patient-centred system of care started about a decade ago, as persons living with the disease began to work collaboratively with the medical community and governments to identify their treatment needs. More and more, care is being tailored to the specific requirements, circumstances and rights of individual patients.

This model is also being taught in Canada's medical schools and teaching hospitals and it is fast becoming an accepted model of care in many other areas, such as in the treatment of breast cancer, multiple sclerosis, diabetes, arthritis and other diseases.

Over the next two days, I understand that you will be discussing new approaches in a number of areas, including the special needs and circumstances of women living with HIV.

This is a particularly difficult situation since many are single mothers. They require not only increasingly flexible child care, but must also face the distressing problem of finding new caregivers and guardians for their children when they are no longer able to care for them.

Another area is the mental stress associated with being diagnosed as HIV positive or with AIDS. It has significant neurological repercussions as the disease progresses. This mental stress often requires special medical and social service interventions.

By working together, Canada, Mexico, the United States and other nations can benefit from our combined experience and expertise. We must continue to take advantage of every opportunity to cooperate, listen and learn from each other.

I sincerely hope that these symposia will identify new opportunities for collaboration and partnership that will help us overcome this disease as quickly, efficiently and effectively as possible.

I thank you for joining us this evening.

May your discussions be informative and productive. And may you leave Vancouver with a renewed sense of hope that we will see a cure for this disease.

Thank you.



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Speech / Discours

Speaking Notes
for
The Honourable Hedy Fry
Secretary of State for Multiculturalism
and the Status of Women

Luncheon Remarks

Canada/U.S./Mexico Satellite Symposia
on
Innovative Partnerships in Education and Care

XI International Conference on AIDS
Vancouver, British Columbia
July 9, 1996



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23/96

Thank you. Dr. O'Shaughnessy, Secretary Shalala, Professor de la Fuente, distinguished guests, people living with HIV and AIDS, my fellow 'speakers', ladies and gentlemen:

Dr. O'Shaughnessy, Minister Dingwall thanks you for all the excellent work you have done on this symposium. He also want to recognize the work you do as the Director of The British Columbia Centre for Excellence in HIV/AIDS which is one of this country's most respected institutions for meeting the needs -- not only for people with HIV/AIDS -- but also for the physicians, researchers and health care workers who provide them care.

As you have witnessed by our involvement here today, our three governments are committed to address -- as a shared priority and also through joint initiatives -- the challenges and issues related to HIV and families, communities and caregivers.

Just a few minutes ago, we signed a joint Declaration which reads, in part:

Our three nations recognize that HIV profoundly affects individuals, their families, caregivers and communities. Today, we are acknowledging those who support HIV affected persons as a shared priority of our nations.

The Minister is pleased that the joint declaration recognizes the need to develop supportive social environments. This is a key principle of Health Canada's **National AIDS Strategy**.

One of the growing areas we must address is the issue of HIV-positive mothers and children. We have learned from the experiences of other countries and want to help ensure that we build on these experiences to assist mothers and children.

To do that, we must improve access to counselling and testing for women in their reproductive years in order to reduce the rate of vertical transmission of HIV from mothers to their unborn children. We also need to find innovative ways to address concerns related to the availability of supportive social environments, adequate and appropriate health and social services as well as supportive systems and networks.

HIV-positive parents face unique dilemmas, and society also faces difficult issues. Not the least of which is the economic impact of HIV/AIDS on family wage earners and the consequences for children who are HIV positive. These are all problems that we need to face, both within and between nations. The Joint Declaration was signed in the spirit of increasing our collaborative efforts in addressing HIV and AIDS issues.

The theme of this conference is "**One World, One Hope**". We have reason to be hopeful, because positive things have happened in the global campaign against HIV/AIDS. We have developed more effective treatments. There is growing recognition of the need for culturally-sensitive, patient-centred care. More educational resources and training are available for caregivers.

We know that we have a long way to go. We know that there is not yet any cure which will put an end to this disease.

But, we also know that with every new discovery and with every new advance, we are getting closer to the day when this illness will be defeated.

Tens of millions of people around the world hold this hope in their hearts.

Minister Dingwall sincerely believes that the message we will send out from this Conference is that they have reason to continue to hold that hope because as each day passes, we are getting closer to the day when this disease will be nothing more than a sad and tragic memory.

Thank you.



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Speech / Discours

Speaking Notes
for
The Honourable Hedy Fry
Secretary of State for Multiculturalism
and the Status of Women

Scholarships Breakfast
XI International Conference on AIDS
Vancouver, British Columbia
July 10, 1996



Check Against Delivery

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Canada

Good morning. Welcome to this special breakfast.

I am pleased that, because of the Health Canada scholarships, you have been able to attend this Conference. And you will bring the knowledge gained here, back to your communities where you will continue your valuable contribution. I am also pleased to welcome others who have made important inroads in the fight against HIV and AIDS in Canada.

We learned some time ago that partnerships with AIDS service organizations, and particularly the involvement of persons living with HIV/AIDS, is critical to the development of effective prevention, care, treatment and support programs.

Since becoming Minister of Health, David Dingwall has met with numerous representatives from the HIV and AIDS communities across the country, from researchers to activists, some of whom are with us today.

I can assure you that he feels there is solid support for a continuing national commitment to fight this disease.

I want to assure you that Canada's investment will continue in arresting the spread of HIV/AIDS and in providing care, treatment and support for those infected.

I am also pleased that the Government of Canada has been able to bring so many of you to this conference. Our main objective was to make sure that your voice -- the most important voice in these discussions -- was heard loud and clear. And I am particularly pleased to note that every Canadian who applied, had at least their registration paid.

I want to recognize the help received in implementing this scholarship program from the Canadian AIDS Society and the Canadian Hemophilia Society.

This cooperative effort is an excellent example of how we can work together to ensure the most effective use of resources. I thank those organizations for their help and support.

But most of all, I want to thank each and every one of you for making the journey here to Vancouver. I know that many have travelled great distances to participate in this conference, and I sincerely hope that you are finding it worthwhile. I admire your dedication and conviction.

I sincerely hope that everyone who has come to Vancouver will take away the message of hope that is becoming such a prominent part of this meeting.

Thank you again for coming to this special breakfast and for taking part in this historic conference.



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Speech / Discours

Speaking Notes
for
The Honourable Hedy Fry
Secretary of State for Multiculturalism
and the Status of Women

Luncheon Address



Launch of *The Business Case for HIV/AIDS*

XI International Conference on AIDS
Vancouver, British Columbia
July 10, 1996

Check Against Delivery

25/96

This is indeed an historic conference on AIDS.

I am aware that a great deal of work has already been done by individual Canadian corporations in collaboration with AIDS service organizations.

People see your presence here as a clear and unmistakable signal that a great number of business leaders in this country and around the globe want to be part of the solution to the challenge of AIDS.

That was certainly the feeling coming out of the Global Business Response to AIDS forum in which some of you participated just a few days ago here in Vancouver.

I understand that a consensus statement was developed at the Global Business Forum that outlines a world-wide corporate commitment to address AIDS issues.

On behalf of the Government of Canada, I congratulate everyone involved in shaping such commitments. They are important additions to the struggle.

The national and international business community understands that they have an important role to play. This involves helping their own employees deal with the issue, providing financial and technical support for research, prevention and care, treatment and support of persons living with HIV and AIDS within their own communities and across the country.

Such commitments provide critical affirmation that a good portion of the business community does understand that the theme of this conference *One World, One Hope* involves more than the people living with HIV/AIDS, the researchers and the many AIDS service organizations and governments. It also includes the business people of this province, this country and of every country.

I want to emphasize some of the facts that impressed me when considering the impact of this disease on businesses and the people who work in them.

In Canada, many people living with HIV/AIDS are full-time employees.

Estimates show that a person living with HIV/AIDS costs the health care system an average of more than \$100,000. And business contributes on average, an additional \$100,000 to cover employee benefit plans. There are further costs of replacement and training when an affected employee can no longer work.

As previously mentioned by Dr. McCallum, the human capital destroyed by AIDS in Canada alone is estimated to have been in the range of \$8 billion in 1995 and is expected to reach \$15 billion per year by the turn of the century.

By the year 2000, the World Health Organization forecasts 30 to 40 million HIV infections worldwide making it a truly global, and a truly enormous challenge for all societies to conquer.

As the number of cases increases, the percentage of businesses affected also grows. So the question is not *will* HIV/AIDS affect your business -- but *when*.

Finally, a rather cold hard fact. HIV is not like other diseases. It is preventable. It is transmissible. And until we find a cure -- it is deadly.

Given these facts, it is no surprise that many of the more socially responsible corporations have already moved to take action.

That is the primary reason why, on behalf of the Minister of Health, David Dingwall, I am pleased to announce **The Business Case for HIV/AIDS** developed by Health Canada in cooperation with the HIV/AIDS community and the private sector. Some of those involved are with us today.

This announcement responds to a commitment to facilitate private sector involvement outlined in Phase Two of Canada's **National AIDS Strategy**.

I am proud to say that Canada is one of the first countries to develop such a comprehensive tool for use by the private sector and non-governmental organizations.

Glaxo Wellcome, Molson Breweries, the Royal Bank of Canada and the Canadian Pacific Charitable Foundation have initially endorsed this document. These endorsements are a strong message and a challenge to corporate Canada.

The Business Case for HIV/AIDS is designed to motivate and encourage Canadian businesses to get involved in HIV/AIDS related activities and to help build partnerships between the HIV and AIDS community and the private sector.

To support this partnership, Health Canada is looking for collaborative opportunities with the business and the HIV/AIDS communities to put the Business Case into use through such activities as appropriate training.

The Business Case is also intended to be a kind of "How To" guide to help businesses come to grips with the unique challenges presented by HIV and AIDS in the workplace.

We have therefore developed this document as a resource for businesses to establish the programs and policies to manage HIV/AIDS effectively and with the compassion and foresight that are so vital.

The Business Case focuses on five steps that companies can take to address these issues. It is a call to corporations to take action.

The first step is to develop an HIV/AIDS policy in the workplace. This includes the information and the steps necessary to help prevent the type of discrimination and disruption which arises when co-workers are fearful and misinformed about the disease.

Ignorance can be a powerful and destructive force. Some companies have found that out the hard way in trying to deal with this issue in the workplace. For example, in one organization, when employees first learned that a colleague was HIV positive, they literally ceased performing, for sheer lack of understanding of the disease.

That is in part why the second step suggests that corporations might develop an education program which tells all employees what the disease is, how it is transmitted and how they can reduce their own risk of becoming infected.

The third step is to launch a public education program about the disease as an external communications initiative to key target audiences.

This will help demonstrate that the business takes its social responsibilities seriously while at the same time providing the much needed message to key publics about important topics such as prevention.

The fourth step encourages companies to provide resources to HIV/AIDS organizations to carry out the research, prevention, education, care, and support for people living with HIV and AIDS.

This is one area where many companies have actively been involved and I acknowledge that over the years Canadian corporations have gone a long way in providing funding, donations, expertise and volunteers to AIDS service organizations.

The fifth step is to help companies become business leaders in HIV/AIDS activities. That is, having established programs of their own, they then move out into the business community to encourage other businesses to take an active role.

That is what the Workplace Coalition on AIDS here in British Columbia is doing. It is helping to develop and promote workplace initiatives including education, policy development, community involvement and other initiatives. This coalition is the first of its kind in Canada.

The initial endorsement of **The Business Case for HIV/AIDS** can help develop a national business coalition.

Such a coalition can be charged with challenging Canada's corporate community to make a long term commitment to the issue.

Indeed, building partnerships and encouraging more involvement of all sectors of society is what our approach is all about.

As I said, I think that here -- at the largest Conference on HIV/AIDS to date -- one of the reasons for optimism and hope is that more and more people *are* joining the fight and adding their support to the worldwide struggle against this disease.

And that optimism also comes from the fact that research worldwide is moving toward a cure and toward better methods of treating people living with HIV/AIDS.

Of course, we know we are not there yet -- and that perhaps we have a long way to go in the fight against HIV/AIDS.

So, in closing, I congratulate the Business Case endorsers for providing leadership to challenge others to become involved in the struggle to end this devastating disease. And, on behalf of the Minister of Health, I thank all of you for your commitment and for taking the time to be with us today.

Thank you.



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Speech / Discours

Speaking Notes
for
The Honourable David C. Dingwall
Minister of Health



At the
129th Annual Meeting of the Canadian Medical Association
Sydney, Nova Scotia
August 19, 1996

28/96

Canada

I want to thank your President for his kind and gracious welcome.

I am very happy to join those who have already welcomed you to Cape Breton. I would like to thank the Canadian Medical Association for inviting me to speak to you as the Minister of Health and on behalf of the federal government.

The pressures you and other health professionals are facing are unprecedented. Reduced resources. Longer hours. A greater workload. Staff shortages. Less easy access to the tools that you believe are essential to stewardship of the health of those you have dedicated your lives to serve -- your patients.

Some would have Canadians believe that your concerns are not warranted -- or that they spring from self-interest rather than good conscience. They are wrong. The medical profession has always been frank and straightforward in expressing its views. And far from simply complaining, you are contributing concretely to solutions. You are doing research that has to be done, detailing policy options that need to be on the table, encouraging the dialogue among the various health partners that must take place.

The future of health care is far too important to be left to governments alone. Doctors are essential participants, key leaders. I salute your contribution. I look forward to working with you.

Your clarity and honesty deserve clarity and honesty in return.

And so, let me begin with some basics.

It is clear that the pressures on the health care system in this country are unlikely to subside any time soon. In fact, they may well increase. Demographics alone make that clear. Equally, while we must do what we can to control technology's cost and utilization, we all know that the bill will remain very, very high.

Finally, while the fiscal health of Canadian governments is clearly improving, continued constraint must be seen as a prospect for the long haul. That's simply a fact of life.

This is a sobering reality. The issue is, how do we manage it? Collectively and individually, each of you will have your answers to that question. Today, speaking as Minister of Health, I will provide mine.

Let me start with a straightforward statement about attitude. I believe we will succeed if we are determined to succeed. If we work together -- as partners in the preservation and enhancement of a health care system that is envied around the world -- I have no doubt we can rise to the challenge. And if we set a standard -- not of survival, but of improvement -- then I have no doubt you will help ensure that standard will be met.

In my view, there are two fundamental challenges facing the health care system in this country.

The first is the desire on the part of some to discard one or more of the fundamental principles of our system -- in effect, it would seem, to throw some principles overboard in order to preserve others. A sort of solution by triage.

But the second challenge facing health care is equally serious: the refusal on the part of others to contemplate new directions of reform. In my view, there is no greater threat to health care in this country than a stubborn insistence on standing still.

Thirty-one years ago, the Prime Minister of this country spoke to one of the final, pivotal federal-provincial meetings that put Medicare in place.

He said: "I believe that Canadian attitudes and Canadian economic standards have now developed to the point at which we are ready to regard Medicare as a part of Canada's basic social standards ... It is now (our) responsibility (to make) Medicare financially possible for all Canadians. The government accepts that responsibility".

Three decades later, let me speak to the three elements of Mr. Pearson's statement: Canadian attitudes, Canadian economic standards, and government responsibility.

On the question of attitudes, I do not think it is an exaggeration to state that there is no question of public policy on which the fundamental values and beliefs of Canadians is more clear. They see it as fundamental to their security and to their families, fundamental to their future, fundamental to the very essence of our country.

Someone once said that a country should not be defined by a program, that it must be much more than that. Well, on this one issue, I cannot agree. The values behind Medicare do define this country. If we lose them, we lose part of our national soul.

Medicare was, and remains, an act of national affirmation, a collective view of what we want to be -- and what we refuse to become.

Among other principles, the desire for universality reflects a view that in a civil society no one should be left outside due to the fact that they are sick.

The principle of equal access is anchored in a belief that relative advantage in wealth should not be an advantage in securing medical care. That, in effect, the standard of life is more important than standard of living.

That the need for care, not the ability to pay for care, should determine access to necessary medical services. And so, as a society we have made a decision to share the risk, share the responsibility, share in rights equally across the country.

On these issues, are contemporary attitudes different?

None of us should be governed by polls. But they do have their place. For example, a major, national poll made public this year, contains some compelling findings: the view that health care should be at the very top of priorities for the federal government; that of all publicly financed systems, health care was the only one where satisfaction was expressed by a majority of Canadians; that in terms of quality of life health care is seen as Canada's most important social program; and that equality of access is seen -- by far -- as the most important aspect of health care in our country.

An even larger majority rejected the idea that individuals should be allowed to pay extra to gain quicker access to health care services.

Now, I am not here to display or debate polls. My point is simply this. I believe that if any Canadian government were to move against the fundamental principles of Medicare, it would be betraying the trust of the Canadian people.

Speaking as Minister of Health, and on behalf of the Government of Canada, that trust will not be betrayed.

But the preservation and enhancement of Medicare is about more than attitudes, more than values. It is also about economics, on which some of you have spoken to me privately and in more formal dialogues in the last number of months.

There is a trend among some, especially on the right, to see health care as just another good, that we should be able to buy health care like we buy a pair of shoes or a second-hand car.

But the reality is, the market does not work well in health care. Demand is not predictable. We don't know when and how we will get sick. Individual expertise is not there to make rational choices when they have to be made.

Life and death situations can make 'shopping around' impossible. The consequences of a 'bad choice' can be catastrophic. The incentives are inherently such as to always leave some people outside -- demand without supply.

While improvements are always possible and reform is certainly needed, there can be no question that a single-payer publicly-funded health system is the most efficient health care system possible.

The facts make that clear.

Before Medicare, Canada and the United States spent an equivalent amount of money on health care -- roughly 7.5 per cent of GDP. Today, we spend just over 9 per cent of GDP on health care. The United States spends close to 14 per cent.

A Harvard study -- not a study done by Health Canada -- demonstrates that Canadians pay \$272 per person per year for health care administration and overhead. Americans pay \$615 per person -- and that's in U.S. dollars.

A study conducted by the Agri-Food Competitiveness Council found that American employers pay anywhere from three to five times more than Canadian employers to fund employee health and social benefits -- and that includes the taxes they pay for those benefits in Canada.

The U.S. Government Accounting Office has concluded that if the United States were to adopt our single-payer system, the savings they would achieve would be so large they would be sufficient to provide free coverage for the estimated 40 million Americans currently without health insurance.

The point is a single-payer publicly funded system is inherently superior. Why?

Because it covers everyone, the economies of scale lead to lower cost. Because there is no discrimination or rating, huge administrative costs are avoided. Because the system is financed through taxation, there is no need for a separate collection process. Because payments to providers come directly from government, there is no need for the

proliferation of all the stages and billing practices that are part of a multi-payer system.

It is no surprise that since 1992 public health expenditures have declined, while private spending outside the Medicare system has grown -- five to six per cent, on average, per year. That's not offloading. The trend started well before cuts in provincial health care benefits.

When some people criticized President Clinton's complex health care reform package, they derided the fact that his plan was three inches thick. Well, the point is it almost had to be, given the near impossibility of providing universal coverage in a multi-payer system.

The case is made that we can't afford Medicare any more. The reality is that we can't afford not to have Medicare in this country.

Let me turn to the belief that private insurance for medically necessary services may be the answer to the pressures we face. I believe that debate is needed, and I welcome it. But as part of that, let me state the position of the Government of Canada.

For the reasons I have described, any movement in the direction of a multi-payer system would be more expensive for Canadian society.

But there is a second point. As a matter of logic, it is impossible to envisage how a multi-payer system would not lead to a two-tier system. People who purchased extra insurance with extra money would presumably do so to get extra service. Either shorter waits, newer technology, more tests, better facilities or less busy doctors. Those who could not afford the insurance would not have access.

Those who could, would. That's two-tier medicine. It's not on. I choose my words very carefully. Access to Medicare in this country has never been about "response to personal preferences". It's about need. And it's going to stay that way.

But let me be clear. If that is not an option, neither is standing still. Benign neglect is totally unacceptable.

We did not build one of the best health care systems in the world by rejecting change. We will only keep that system - and enhance it - if we accept it must and can be improved.

For the federal government, the objective is clear: the preservation and enhancement of our national health care system.

The first way to achieve that objective is to maintain our commitment to ensure the long-term future of Medicare. In terms of funding, I believe we have now done that.

Provinces sought stability, predictability and security in federal funding. They now have it. A cash floor for federal transfers is in place. Overall transfers will begin to rise in the future.

No one can be happy about the decisions that have had to be made to reduce transfers. But I believe sufficient resources are now in place, from a federal perspective, to secure the foundation of Medicare, to enforce the *Canada Health Act*, and to give the provinces the confidence they clearly need to proceed with their various reform processes.

I believe the federal government cannot, and must not, make any further cuts to transfer payments for the purposes of health.

But important as that is, it is far from sufficient. Which leads me to our second priority. We need to reduce costs and demands arising from within the system -- and costs and demands arising from outside. The goal must be a better balance between treating illness and measures to promote good health, protect health and prevent disease.

As we look to the future, an improved health care system for Canada rests as much as anything on improved health for Canadians.

I know that whatever differences we may have on some issues, there are many on which there is common ground. You are providing leadership in many of those areas. From a federal government perspective, we are pursuing complementary initiatives of reform and renewal.

First, we must restore trust in the institutions that lie at the heart of our health care system. That includes Canada's blood system. On April 25, I met with my provincial counterparts and we agreed on the principles and essential elements of a renewed system. We meet again in September. We will be ready to move quickly when we receive the recommendations of Justice Krever.

Second, as you yourselves have argued strongly, we need to do the research required to bring evidence-based decision making to health care -- across the board, from treatment to prevention. Knowing what does work -- and what doesn't, knowing the risks and the rewards, is essential to both more effective and less costly medicine.

It is for that reason that in the last budget, we announced our firm commitment to the creation of a Health Services Research Fund, to be administered by the Medical Research Council on behalf of Health Canada and other partners. This is not going to be a government program. It recognizes that the business of funding research has to be just as imaginative and creative as the research endeavour itself.

Third, as a country, it is high time we treated the issue of women's health as a matter for action, not simply rhetoric in speeches. That is why in June, I announced the sites of five centres of excellence for women's health across the country; why, together with my U.S. counterpart, we just held the first and very successful Canada-U.S.A. Women's Health Forum; and it is one of the major reasons why we will complete a comprehensive legislative package this fall to regulate and control new reproductive and genetic technologies. The standards of safety, access and human dignity must be and will be upheld.

Significant as these steps are, we need more than individual initiatives. We need a comprehensive approach.

To meet that need, I will be announcing in the coming weeks details of a Women's Health Strategy for Health Canada. This strategy will ensure that every aspect of Health Canada's work in the health field -- be it health information and surveillance, regulatory activity, research, policy or health promotion and disease prevention programming -- is responsive to the particular health needs of Canadian women.

Ultimately, our aim is to ensure that the entire health system more explicitly responds to the health needs of women. And you, as physicians, have a key role to play. Your decisions about care and treatment, about what preventive or diagnostic tools to use, about what drugs to prescribe, are what determine whether the immediate, real health needs of women are addressed.

Other areas for action are clear. They include fitness, environmental health, workplace safety, nutrition -- particularly children's nutrition, and concerted efforts to address the causes of the still appalling health conditions among aboriginal Canadians.

But there are two issues in particular on which I would ask for your support today.

The first is the question of pharmaceuticals.

Contrary to what the public perception may be, direct compensation of doctors is no longer a cost driver in our health care system. In fact, as a proportion of total health expenditures, it is stable.

The biggest cost driver today is drugs. In 1994, they constituted 12.7 per cent of total health expenditures, up from only 8.8 per cent only two decades ago -- more than \$9 billion or roughly \$300 per Canadian per year.

Those costs must be brought under control. By far the most important factor driving cost is utilization -- and it's growing at a disturbing rate. Patients need to become more engaged and educated in their patterns of usage. Drug companies must bear responsibilities too. They are the producers and the marketers. And doctors play a key role. You are the gatekeepers to prescription medicine.

One area of possible joint action may be the provision of much better information for doctors on availability, efficacy and the cost effectiveness of pharmaceuticals -- information that is both up to date and objective. We should not accept a situation where too often -- because of the pressures of time and the rapid progress of science -- doctors are forced to prescribe based on sales pitches, not solid evidence.

At our meeting in April, federal and provincial health ministers agreed to address urgently the question of drug prices, utilization, wastage, marketing, research and development and consumer education. You have already initiated valuable work on prescribing guidelines with the Canadian Pharmaceutical Association. But I believe we can -- and must -- go much further. Today, I challenge the pharmaceutical industry to work closely with you and with me and provincial governments to address this national priority.

The second issue is tobacco.

As physicians, you are more familiar than most with the devastating effects of tobacco use. Globally, it accounts for one death every ten seconds. In Canada, it is the leading cause of preventable death and disability, resulting in three times more deaths than those caused by car accidents, suicides, drug abuse, murder, and AIDS combined.

In economic terms, smoking-attributable costs -- including health care costs and lost productivity -- are estimated at \$15 billion each year.

Tragically, young Canadians are the most vulnerable to tobacco addiction. The majority of new smokers are 12 to 14 years old, and most of them will be hooked for life despite believing that they will be able to quit whenever they want. More than 40,000 Canadians will die prematurely in 1996 as a result of tobacco-related causes, and the kids starting to smoke today are the next generation of grim statistics.

That is why it is so important to move to replace the tobacco control legislation struck down last September by the Supreme Court of Canada. If we are to reduce tobacco use, particularly among young Canadians, we must regulate the production, promotion, labelling and sale of tobacco products, as well as access by minors to tobacco products.

I expect that some will argue that such legislation is not required, and that the tobacco industry's self-imposed voluntary code on advertising should be given a chance to work. I disagree. These voluntary restrictions do not go far enough, and I am just not convinced that the industry's objectives and conduct will ever be compatible with the health goals that you and I share.

I also expect that any restrictions on the promotion of tobacco products -- whether through advertising or sponsored events -- will be very contentious. Many are already lining up to vigorously oppose such legislation, just as they did with the *Tobacco Products Control Act* almost 10 years ago. There is no question that the road ahead will be difficult, but I am encouraged by the dedication and determination of organizations such as yours in the fight against tobacco use.

The Canadian Medical Association has been extraordinarily supportive of our tobacco control efforts in the past -- in its own right, and in partnership with others.

It is understandable that the constraints we face and the pressures before us would lead some to see a future for Medicare that is but a pale imitation of the past. And that risk is there. We would be fools to ignore it. Which is why we must act.

But I believe we should look to a larger vision, one that encompasses what we might be able to achieve once the current challenges are met, a vision that can sustain us through this difficult generation of change.

Some would say we must contemplate entering the new millennium by leaving Medicare behind. I believe we must plan now to enter the new millenium in a position to make Medicare stronger still. If we work together, I believe that can be our goal. More than that, I believe it can be our accomplishment, a legacy worthy of that which was passed onto us.

On health care, it is time to be serious about partnership -- all of us, the federal government, the provinces, doctors, nurses and every other health care partner. If there is one issue on which Canadians will not tolerate turf wars, it is health care. They have entrusted the system to us. They want us to protect it, not fight over it. Canadians deserve light, not heat.

If we succeed in meeting the challenges we face, it will be in large part because of the high standards you, as Canadian doctors, have always set -- professionals whose view of your own interests is infused with an abiding sense of the larger interests of the society you serve so well.

I call on you today to continue in that proud tradition of leadership, putting aside solutions from the past, looking ahead, helping to renew Medicare as stewards whose focus has always been far broader than that of any narrow cause, encompassing the well-being of an entire nation.

The public trust you have earned is unparalleled among occupations. Canadians look up to you, just as you look after them. Governments need your help and leadership now more than ever. I am confident that Canadians can count on you to provide that leadership.



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Speech / Discours

**Speaking Notes
for the
Honourable David C. Dingwall
Minister of Health**

at the

**Second National Conference on Tobacco or Health
Ottawa, October 31, 1996**



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36/96

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Thank you for your kind invitation to be here today.

This is indeed a privilege. There are many important causes in this country. But few are as important as reducing tobacco use. Your unstinting efforts to help 'make smoking history' in Canada have never been more welcome -- or more needed.

In the past few months, I have often talked about the priority I place on reducing tobacco use. But I have not had an opportunity to devote an entire statement to this issue. This conference is a welcome opportunity to do so now.

As Minister of Health, I consider the fight to reduce tobacco use and addiction fundamentally linked to our overall health priorities. It is a key element in fulfilling this government's commitment to preserve and enhance Medicare as our national health care system.

Built on the five principles of the *Canada Health Act*, Medicare ensures all Canadians have equal access to health care in Canada -- when they need it, wherever they need it. But as we all know, the system needs modernization. We must make it affordable. We must seriously examine the many factors that drive up costs. We must bring it into the 21st century by strengthening our research into what works best. We must make decisions that affect health care, treatment and prevention based on the results of that research.

And, we must change the way we use the system. We must focus on the health of Canadians.

We have learned a great deal in recent years about the many factors that influence health. These determinants of health include a very broad range of factors from a person's income, education, physical environment and social support networks to their genetic make-up. But they also include individual behaviour and personal choices.

Recently the federal, provincial and territorial governments issued the first *Report on the Health of Canadians* which documented the clear linkage between the determinants and the health of the population. The Report noted a disturbing trend in unhealthy behaviours -- behaviours like smoking and lack of exercise.

One of these personal choices -- smoking -- is the leading cause of premature death in Canada. Tragically, it is a choice made by many people at a very young age.

Indeed, young Canadians are the most vulnerable to tobacco use and addiction. Their decision to smoke today will have profound consequences on their health in later life -- and on the health care system. Their well-being must be at the heart of our efforts to control tobacco use.

Since the Government released the Blueprint on tobacco control last December, we have been working to develop new legislation.

Putting together a comprehensive and reasonable package that is both powerful in what it will do -- and at the same time able to withstand legal challenge -- has been far more complex than even we had imagined.

The last thing any of us want are laws that don't do the job. We are committed to getting this right -- and we will.

I myself have always asked people to judge me not by what I say, but by what I do. On this issue, I am more than willing to meet that test.

Today, I want to lay before you the rationale for what we will do.

Much of what I am about to say, you will have heard before. Certainly, many of you have built a public record on these issues that goes well beyond mine. But these facts and these arguments can never be made too often.

Let me begin with the health facts. There will not be one person in this room who is not painfully familiar with them. But not enough Canadians are -- not enough young people are. We must continue to drive them home.

More than 40,000 Canadians will die this year as a result of tobacco use. That is three times the number who will die from car accidents, suicides, drug abuse, murder, and AIDS combined.

Seven million Canadians -- one in three over the age of 15 -- are currently victims of tobacco addiction. The vast majority of them wish they had never started. The vast majority of them will not be able to stop.

Today, one in three of our young people smoke. Half of these young smokers will die from it. Other governments and the World Health Organization realize this is a global paediatric epidemic.

These are disturbing facts. But as real as they are, there is a larger and more encouraging picture that is emerging. I believe we have reached the pivotal point in the long struggle to address the tobacco issue.

The evidence is everywhere.

Throughout Canada, municipalities are taking strong action to ban smoking. Employers -- like Safeway, Air Canada, MacDonald's and Tim Horton's -- have enacted smoking restrictions in the workplace, often ahead of the law. Non-governmental organizations are also helping to make Canadians recognize that smoking, and second-hand smoke, kills. The bottom line: to more and more Canadians, smoking is clearly a health hazard.

In the world of public policy, tobacco used to be seen as much as an issue of industry, jobs and profitability as it was of health.

We can now say with confidence that that era is by and large over, once and for all. Tobacco is about health, full stop.

Last December, in the aftermath of the Supreme Court decision, my predecessor released the government's Blueprint for tobacco control. Let me assure you, the Blueprint has been -- and remains -- my guide. The legislative package will be comprehensive. It is being designed to withstand any court challenge. It will return this country to the front ranks of global leadership on tobacco control.

What will we do? The package will deal with:

- ◆ advertising
- ◆ promotion, including sponsorship
- ◆ packaging and labelling
- ◆ access
- ◆ enforcement of the law on sales to minors
- ◆ smuggling
- ◆ education
- ◆ product regulation
- ◆ reporting requirements

The tobacco industry has adopted a comprehensive and integrated approach to marketing. Our approach will also be comprehensive and integrated. Anything else would be naive. And anything else would fail.

Canadians must see this as a health issue, not as a jobs issue, or a freedom of choice issue.

Some people claim that because tobacco is a legal substance, people should be free to make their own choice. Let's take a look at that logic.

First, there is no doubt that if we knew before tobacco use became pervasive what we know today, tobacco would indeed not be a legal product. As a practical matter, you cannot render illegal a product to which seven million Canadians are addicted.

Second, the Supreme Court clearly ruled that the control of tobacco advertising is a valid exercise of the federal criminal law power. It is a power we intend to exercise fully.

Society has a stake in this issue -- a stake measured in \$15 billion each year in economic and health costs to our society, a stake measured in the hundreds of Canadians who die every year from second hand smoke.

Yes, tobacco is a legal product. But for the reasons I've indicated special restrictions are warranted.

Where, then, does the tobacco industry stand? The tobacco industry says its voluntary code should be sufficient.

We know that since the very day the code was put forward, the industry has violated it.

The tobacco industry says that it does not advertise in order to convince people to smoke. It says it is only encouraging the switching of brands. It claims that it does not focus on youth -- that its audience is entirely adult tobacco consumers.

The views of young people are very clear, despite what the industry says. Of the majority who are aware of sponsorship, more than 80 per cent -- smokers and non-smokers alike -- see sponsorship as a way to advertise cigarettes.

The industry says no one ever started smoking because they attended an event sponsored by a tobacco company. That's not the point.

It is clear that the intent of tobacco advertising is to create a society where in every store, on every street corner, near every school, on every medium possible, at every venue conceivable -- there are images of tobacco. A part of the landscape. A part of the mindscape. A part of life -- an appealing life, a sophisticated life, an athletic life, a successful life -- a sensory and emotional assault designed to reassure young people, in fact to convince them that there is something wrong with them if they don't smoke.

Of course, the focus of the tobacco industry on young people is understandable commercially, but that does not mean it is acceptable.

It is not simply that young people are more impressionable, more willing to believe that they're invincible, that they can quit if they want to, that they won't die.

Just as the life of the tobacco industry is anchored in a deadly habit, so too the death of Canadians requires new smokers. If young people did not decide to smoke, the industry's bottom line would suffer. In order to replace those who die and those who quit, the industry needs new customers. Lots of them. And because with very few exceptions it is not adults who make the decision to start smoking -- the new smokers are young and getting younger. According to the *1994 Youth Smoking Survey*, 260,000 kids between the ages of 10 and 19 took up smoking that year.

It is why we must do everything we can to ensure that the law on sales to minors is enforced.

I have talked about the need for, and the nature of, our upcoming comprehensive federal strategy.

But, as you all know, a comprehensive strategy on smoking does not stop with the federal government, nor only with legislation, regulation and law.

The engagement of every level of government is warranted and welcome. That is why I am heartened by the support I have received from my provincial and territorial colleagues, who, regardless of political stripe, all face the same health burden and costs that smoking creates.

It is why the initiatives of municipalities such as Vancouver and Toronto, are so important.

It is why the actions of medical and public health experts, community groups and non-government organizations, so many of whom are here today, are so critical. Your efforts, along with those of government, to educate Canadian children about tobacco, are vital. We must fight this war on the battlefields that ultimately count -- in the school yards, the classrooms, the council chambers of this country.

It is why we must engage young people -- as we are with the Youth Advisory Committee on Tobacco, which I established earlier this year -- because if peer pressure plays a major role in the decision to smoke, we need to know how to make peer pressure part of the decision not to smoke.

Sarah Viehback, the Co-chair of my Youth Advisory Committee is here with you to share her work with the Fly Higher Program.

We need more than ever the engagement of parents who must never allow themselves to see cigarette smoking as some inevitable rite of passage for their children -- something they will get over, grow out of. Because the bottom-line is, the vast majority of teens who are regular smokers won't.

Let's not let up. Let's continue to inform and remind Canadians that this is the biggest public health problem we have. Let's keep the focus on health.

My commitment to you is that as you do your part, we will do ours.

And my belief is that if we stick together -- and stick it out -- history will record that you, and the thousands upon thousands who stand with us, will succeed in achieving a healthier Canada.

Thank you.



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Speech / Discours

Speaking Notes
for
The Honourable David C. Dingwall
Minister of Health

Canada Foundation for Innovation
Ottawa, February 19, 1997

Check Against Delivery

20/97

Yesterday, Canadians heard about the investments this government is making in the future -- investments in children, investments in long-term jobs and growth, investments in health and investments in innovation.

Today, we are here to discuss one of those investments -- the Canada Foundation for Innovation, which cuts across all these areas: children, job creation, health and innovation.

As Minister of Health, my priority is clearly the health of Canadians and the future of our health system. I am delighted that the Canada Foundation for Innovation has a major health component.

Innovative, progressive health research is one of the cornerstones of a modern health system and a vital strategic investment in a high standard of health for Canadians.

Last June, when I convened a roundtable meeting on the future of funding for health and medical research, I challenged representatives of the academic and private sectors to devise innovative solutions to Canada's research problems. Last fall, as I opened the first meeting of international health research funding agencies, I again urged participants to be creative and to pursue the model of partnership in funding research. I am proud to say that the Canada Foundation for Innovation is just such a model of partnership in support of major new funding for Canada's health research sector.

One of the great lessons of the last few years is that governments cannot singlehandedly make Canada a world leader in research or in any other field. The Foundation is a special partnership which promotes innovative, progressive health and medical research for which Canada is already well known, and links it to the great generosity of countless citizens of our country. Working together, the private and public sectors can build, and rebuild, a world class research infrastructure, to ensure that Canadian research continues to achieve international recognition.

I am particularly encouraged by the First Opportunities component of the Foundation which will support our brightest new researchers. Partnerships between the public and private sectors will give these young scientists the equipment and space they need to conduct world class research. This truly is a strategic investment in the future, the foundation will help us to retain and recruit tomorrow's most promising researchers.

This budget firmly supports the renewal and restructuring efforts underway in the health system today. It underlines the government's commitment to the most basic tenets of our health care system: universality, accessibility, affordability. With that commitment to the future of medicare, and the investment in its modernization, I believe we have the tools to move our health system into the 21st century.

I challenge Canadians to take advantage of this historic opportunity to maintain and enhance our global reputation in health sciences. I am convinced that we are equal to the task. Canadians right across this country cherish their health and the system that maintains it. They understand the hope that research provides, and they live out that hope through their support.

In this spirit of national cooperation, the Canada Foundation for Innovation will flourish. I invite all Canadians to join the government in contributing to excellence in Canada's health research enterprise.

Thank you.



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Speech / Discours

**Speaking Notes
for
The Honourable David C. Dingwall
Minister of Health**

**Funding Announcement
Networks of Centres of Excellence
Chedoke McMaster Medical Centre
Hamilton, February 20, 1997**

Check Against Delivery

21/97

Canada

Good morning everyone,

It is a pleasure to be here today with my colleague Dr. Jon Gerrard, the Secretary of State for Science, Research and Development and Western Economic Diversification.

In Tuesday's budget, Canadians heard about the strategic investments this government is making in the future -- investments in children, investments in long-term jobs and growth, investments in health and investments in innovations.

Today, we are here to highlight one of those investments in the future -- the Networks of Centres of Excellence.

Few places show the future better than our universities. Canada's universities, like McMaster, are tackling the science and technology priorities that will help us build a strong economic future. They are building partnerships with the private sector and with governments to find solutions.

The federal government realizes the importance of a strong research sector. Today, we are here to announce an investment in Canada's future. The government will provide \$47.4 million per year for the Networks of Centres of Excellence Program. Our action will stabilize funding and make the NCE Program permanent. It will build on the results to date that have made this program a national force for innovation.

The Networks of Centres of Excellence includes more than a thousand top researchers, 1,400 graduate students and 470 post-doctoral fellows. Those men and women come from universities, businesses, hospitals and government departments across Canada.

They are involved in partnerships that are identifying commercially-viable solutions to issues in health science, engineering, and other fields. These partnerships are creating high quality jobs that tap our country's investment in higher education, research and development.

I know Jon will talk in more detail about the research and development aspects of the NCE Program. As Minister of Health my priority is clearly the health of Canadians and the future of the health system. So, I want to focus my remarks on health innovation and how the NCE Program is helping us address Canada's health priorities.

The budget included a series of strategic investments in health innovations.

- ◆ We are creating a Health Transition Fund of \$150 million to test ways to modernize the health care system in collaboration with the provinces. The funds will help support pilot projects in areas such as pharmacare, home care and evidence-based decision making.
- ◆ We have committed \$50 million to develop an integrated Canadian Health Information System -- a "network of networks" -- linking all players in the health system and making valuable data accessible right across the country.
- ◆ A new Canada Foundation for Innovation will provide substantial financial support for modernizing research facilities and equipment, including health research.

The Networks of Centres of Excellence is another way in which we are improving the health of Canadians.

Six of the fourteen Networks of Centres of Excellence have a health science orientation. Researchers, including many here at McMaster, are working in networks that address bacterial diseases, genetic diseases, respiratory health, neuroscience and protein engineering.

These networks are exploring innovative therapies for many diseases that draw on Canadian strengths in advanced research.

Now, Canada's health needs are not solely on the medical treatment side. We are working to modernize our health care system at the same time. We need strong research work to help us make the right decisions to improve health care delivery in Canada.

One centre, the Health Evidence and Application Network or HEALNet, is based here at McMaster. It is dealing with issues that are very close to the interests of all Canadians. It is developing information-based tools that improve the efficiency of our health care system, and deal with health needs in the workplace. The results of this research can do more than help Canadians manage the health care system better. It can do the same for people in other countries.

When I meet with Ministers of Health from other countries, I find that we are all looking for tools to improve health management. The work of HEALNet means we can export our expertise and solutions. We win through a better and more cost-effective system. We win through jobs.

The Networks of Centres of Excellence Program is an investment in Canada's future. We are pleased to continue federal government support for it.

Thank you.



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Speech / Discours

Speaking Notes
for
The Honourable David C. Dingwall
Minister of Health

Building a Better Health System for Canadians
Board of Trade of Metropolitan Toronto
Toronto, April 22, 1997

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Canada

A. Introduction

Barely one generation ago, our country faced a crucial decision. It was a decision not about war or peace; not about security or state-craft. It was a decision, in effect, about what kind of society we wanted to become. It was the final decision to move forward on medicare.

Those of my generation – and younger – tend to forget how recent that decision was.

Nor do we recall how difficult, how uncertain the debate preceding it had been. Medicare did not have an easy birth. It took time. Discussion was often emotional – far from reasoned.

Governments fought governments. There were confrontations with and between interest groups.

But the country, in the end, came together. The right decision was made.

Almost four decades later, we are at another turning point in the future of the health system in Canada.

It is time once again to decide, to choose. Do we preserve the principles of medicare – or do we let them slip away?

Do we ignore the need for change, or do we embrace it and turn it to our advantage? Must we settle for simply sustaining as much of the old system as we can – or can we not, in fact, make the system even stronger?

In short, it is time to decide on a plan for the future of the Canadian health system, one that can carry us into the next millennium, one that is worthy of the legacy that was passed on to us.

This is not a task for any one of us alone. It is a task for all of us. For governments at all levels and for the private sector, for individuals and organizations.

B. The Context for Change

The fact is, an increasing number of Canadians believe that the system will not be there for them when they need it. This anxiety is real, and it must be addressed.

It must be addressed by demonstrating that answers exist, if we show the will and the wisdom to act decisively. And, despite the emotion this issue inevitably entails, it must be addressed through reasoned discussion.

There can be no denying the pressures and the challenges that face us – both in the short- and the long-term.

First, fiscal restraint simply will not allow for a return to the days of unchecked growth. Consider, for example, that health constitutes, on average, 30 percent of provincial government program spending.

Second, the sustained impact of an aging population will increase demand on the system.

Third, the impact of new technologies and new treatments is fundamentally changing the way care is delivered.

Fourth, the fact that the major cost-drivers in health care today, in particular drugs, often lie outside the publicly funded system.

Fifth, and finally, there is the persistence of broad social and economic problems that themselves are determinants of health – such as child poverty, unemployment, and work and family stress.

The question is, how do we respond to these facts in a way that guarantees better health and access to high quality health care for all Canadians? What is the road forward? What lies along the journey as we move into the new millennium?

C. Preserving the Principles of Medicare

There are some who would have Canadians believe that the answer lies in setting aside the five core principles that underlie our health care system.

Of course, the case is seldom made in those terms.

Its proponents understand how profoundly committed Canadians are to the values of equity and compassion, values that form the foundation of our system.

And so, a different approach is used.

Soft euphemisms are employed – and what is very clearly two-tier medicare is couched in terms of the exercise of “personal preferences” or as health care “pluralism.”

Polls are deployed showing Canadians’ *expectations* of a two-tier health system within the decade, without also noting that this expectation is accompanied by deep opposition.

There are regular clarion calls of ‘crisis’ designed, one sometimes thinks, to get people to accept changes they would otherwise find offensive – making them believe, for example, that a choice has to be made between high quality care and equal access.

There is no doubt that the pressures on those who work in the health care system today are very real. And there is also little doubt in my mind that the vast majority of stakeholders harbour very genuine and sincere concerns for the future – not simply for themselves, but for the millions of Canadians who put their trust in them.

But it should be crystal clear to all Canadians that in health care, just as in every other field, there is something called the public good. There is also something called self-interest. Sometimes the two coincide. Sometimes they do not.

On the proposition that we should set aside one or more of the principles of medicare, my friends, it’s not on. It would simply be bad policy for the citizens of this great country.

The principles that underlie medicare reflect values that are fundamental in Canadian society. But so too are they fundamental to the Canadian *economy*.

The concept of medicare – a single-payer, publicly-funded health system – is *not* the triumph of values over economics. It is the triumph of *both*.

Study after study make this point.

The economic benefits and competitive advantages that arise from our type of system are clear.

Before medicare, Canada and the United States spent an equivalent amount of money on health care – roughly 7.5 percent of GDP. Today, we spend just over 9.5 percent of GDP on health care. The United States spends close to 14 percent.

A Harvard study – not a study done by Health Canada – demonstrates that Canadians pay \$272 per person per year for health care administration and overhead. Americans pay \$615 per person – and that’s in U.S. dollars.

A study conducted by the Agri-Food Competitiveness Council found that American employers pay anywhere from three to five times more than Canadian employers to fund employee health and social benefits. That figure includes the taxes they pay for those benefits in Canada.

Equity and good *economics*: these are the heart of medicare. That is why its principles must be maintained.

Equality of access is not on the table. Private insurance for medically necessary services is not acceptable, because, no matter what the *words* are, the *body language* is very clear: two-tier medicare.

The decision made one generation ago will not be undone. Medicare in this country is about *need*.

And it will continue to be about *need* – not the ability to pay.

D. The Need for Change

Now, if setting aside the principles of medicare is not an option, neither is standing still.

The fact is that the *principles* of medicare will only, in the end, be sustained if the *practice* of medicare – indeed of the entire health system – changes.

That is not simply a federal view. Nor is it new.

Across Canada, there is a consensus that money *per se* is not the panacea, that the answer to our challenge cannot lie in writing ever larger cheques.

The fact is that at a time when money didn’t seem to matter, none of us held the system up to scrutiny.

It had been allowed to expand without the kind of overall strategic planning or management approach that was – and is – being demanded of every other major private and public sector institution and enterprise.

Huge variations in patterns of very costly medical practices have developed across provinces, even within cities – from Caesarian births to drug prescriptions – with no apparent explanation.

And while science is saving lives, curing illness, and reducing the need for surgery through modern pharmaceuticals, a larger and larger part of the financial burden is being borne by patients directly.

Furthermore, total spending on drugs is rising dramatically due, in part, to utilization and prescription practices.

Now, the provinces, each in their own way, are proceeding with processes of reform. The design and delivery of health care is their responsibility. But I want to go on the record today on three issues.

First, on cuts to federal transfers, the fiscal challenge we faced made them necessary. It would be incorrect, though, to say that these cuts are driving health care change by themselves.

For the cuts we have made amount to only about 3 percent of provincial revenues.

Some of the provinces that are reducing or capping health spending are also, at the same time, running budget surpluses or reducing taxes.

And the era of transfer cuts is *over*. Our fiscal discipline has provided the confidence that they will not be cut again.

In fact the transfers will begin to grow within three years. A guaranteed cash floor is in place. This cash floor will ensure a continuing federal role in health, something Canadians overwhelmingly see as a duty of their federal government.

Our position is clear. Cash transfers are essential to enforcing the *Canada Health Act*.

We, unlike others, will not contemplate giving up the capacity for enforcement of the *Canada Health Act*.

The second issue concerns the process of reform itself. I believe the last thing we need is a mad rush.

Let's make sure we get it right. Let's ensure that what we are doing satisfies the health interests of our society for the long haul, not only the fiscal requirements of budgets for the short haul.

That being said – and this is my third point – health care reform, properly planned and carefully timed, should be seen as an opportunity to be pursued, not as pain to be endured.

It is time to give Canadians the confidence they deserve that, as we enter the next century, we will have done the planning and taken the decisions needed to make our health system both more effective *and* more efficient than it is today.

E. Our Vision for the Future: An Opportunity for Action

As a country, it is time to come together and agree on a critical path. There will be debate – and we are willing to lead it. But let me simply say: the purpose of this debate must be *decision*.

The evidence exists to point us in the right directions for the future. The major pillars that provide the evidence are there. They include:

- the 96 Federal/Provincial/Territorial *Report on the Health of Canadians*
- analyses on the well-being of children
- the extensive work on population health, and
- the consultations and the Report of the **National Forum on Health**, which provides a balanced and strategic view of how we can begin to move forward together.

I see a two-pronged approach.

First, we must preserve and modernize medicare based on the reality that *health care* today can be, and should be, about more than hospitals. As the **National Forum on Health** recommended, our organizing principle should be to fund the *care* – not the site where it is delivered.

The second thrust supports the first. We must act on the fact that *good health* involves more than just the *health care system*. We must expand our focus to include greater prevention, promotion, and action on the social, economic and environmental determinants of health.

Acting on these priorities will require creativity, leadership and fiscal responsibility.

F. Priority One: The Preservation and Modernization of Medicare

I have stated that the principles of medicare reflect core Canadian values, that they represent good economics, and that they will be maintained.

But this must only be the beginning.

Today, the medical system has evolved along very different lines.

Extraordinary advances in science have made pharmaceuticals a far larger, more effective component of treatment.

The circle of health care professionals has widened and the settings in which they work have multiplied, but public funding of these services provided in non-hospital settings is far from consistent or comprehensive.

And advances in technology, in treatment, in drugs and in the health care professions are making care in the home a much more effective and welcome alternative to staying in hospital – but, once again, publicly funded coverage is inconsistent.

This is an issue of financial hardship. But so too can it result in profound practical and emotional pressures on families, particularly women, when they are forced to provide care for elderly relatives themselves, very often a parent, while simultaneously balancing work and family life.

The growing gap between the system of health care and the system of public funding must not be allowed to continue.

It can distort medical practice, with patients being put in hospitals unnecessarily – or kept there because they cannot afford out-of-hospital care.

It confounds the logic of medicare itself – because, by any reasonable definition, the vast majority of these services are indeed “medically necessary.”

Therefore, for reasons of equity and efficiency, the National Forum has recommended that we should work to expand medicare to cover home care and pharmacare. I agree.

Today, we are not yet at a point when final decisions on the modernization of medicare can be made. We need to get the foundation right before we build on it. We need to test and evaluate what the best options are. Collaboration with the provinces, health care providers, private payers and consumers is required.

And in pharmacare, in particular, prior work needs to be done to ensure effective cost and utilization control.

Therefore, as part of this process, the \$150 million, three-year **Health Transition Fund** established in this year’s budget will be devoted to working with the provinces to put in place precisely the kind of pilot projects we need to evaluate ways of moving toward this new generation of medicare.

On pharmacare, in particular, new public spending would be required. But if we can come together on a responsible agenda for action to move this forward, let there be no doubt: the federal government must do its part to contribute financially.

To move this process forward, I am pleased to announce today that three national conferences, each to be co-hosted by the federal government and an individual province, will be held this year on pharmacare, home care, as well as health information systems.

G. Priority Two: Health Beyond Health Care

Preserving and modernizing the health care system is the first, essential building block for the future.

Let me highlight the challenge we face.

While we have made progress on many determinants of health over the decades, I fear we may now be stagnating.

We must focus on groups at high risk, in particular at-risk children.

We know that poor children, often deprived of key supports, are at greatly increased risk of higher mortality, substance abuse, poor school performance, decreased mental health and increased illness.

And we know that an adequate income for all of Canada's children – coupled with interventions to support those clearly at risk – are some of the very best health investments we can make.

The fact is that all provinces now have in place a determinants of health framework. Most have strategies that focus increasingly on prevention and promotion. And all support better integration of the full range of health services and of the health care system.

In addition:

- A national effort is now underway, given an important boost by the \$850 million announced in the recent budget, to put in place an integrated **Canada Child Tax Benefit**.
- A \$100 million increase in funding was provided in this same budget for the tremendously successful **Community Action Program for Children** and for the **Canada Prenatal Nutrition Program**.

The government has passed legislation to reduce the exposure of young people to tobacco products and promotion. This is a reasonable approach – tobacco use causes the deaths of 40 000 Canadians every year, and is responsible for \$3.5 billion in direct health care costs.

As we move forward, I believe there are three key points to be made as they relate to the determinants of health.

First, we do not see a focus on the determinants of health as in any sense detracting from, or in competition with, the health care system itself. They are mutually supportive. Resources should not be shifted from one to the other.

Second, while governments can support, encourage and sometimes legislate, many determinants of health are by their very nature matters of individual choice, family choice, community choice and corporate choice.

It is *communities* who must come together and decide to place a priority on fitness programs and facilities, and clean water. It is *employers* who must recognize they have a responsibility to help relieve work and family stress. And it is *individuals* who must decide to stop smoking, control alcohol use and get fit.

The bottom line: a focus on the determinants of health is a focus on our future well-being and prosperity.

H. A Stronger Foundation of Evidence, Information and Research

(a) Evidence and Information

In order to complement and strengthen the two elements of our vision – a modernized health system and greater emphasis on the health of Canadians – it is clear that we must be guided by solid evidence of what works best and what doesn't.

What are the best practices? What options are available? What are the associated costs and benefits?

Yet today there are too many gaps in the information we have, its quality, and the use to which it is put.

Health providers do not always have at their disposal the best evidence and information to supplement their own expertise and experience, particularly in more rural and isolated centres. Yet the technology is there, through such advances as telemedicine, to ensure that the doctor in Churchill is on a level footing with the physician in downtown Toronto.

In short, we must enhance the quantity, the quality, and the dissemination of evidence and information. And we are committed to doing precisely that.

(b) Health Sciences Research

Equally important is investment in health sciences research. We sometimes see this as an elite preoccupation, something that has very little to do with our own health.

But research will determine the cures and the treatments of tomorrow. We know that from our own track record, right here in Canada. The discovery of insulin. The invention of the electron microscope. Of cobalt radiation. Of the mechanical heart. And discovery of the gene responsible for cystic fibrosis.

Important new findings await – on breast cancer, on the cause and cure of Alzheimer's, of diabetes.

Not only does world class research contribute to the health of Canadians – it also helps train and retain our very best professionals, who are able to develop their skills here, rather than going abroad.

And it forms a basis of vast potential for biotechnological, pharmaceutical and other health industries.

That is why we have made *permanent* the **Networks of Centres of Excellence Program** – six networks oriented toward health science – supporting the work of hundreds of top researchers, graduate students and post-doctoral fellows across Canada.

And that is why the \$800 million announced in the last budget for the **Canada Foundation for Innovation** is so important.

One of its core priorities will be innovative and progressive health research, filling the major gap in infrastructure investment for major equipment purchases and construction. As a result, the quantity and quality of health research in Canada is set on a course of major improvement.

This will be bolstered by the steps we have taken to significantly increase the tax incentives for donations to charities, including hospitals and universities.

The fact is, the cures and treatments of tomorrow will not come from happenstance. They demand investment in excellence. And that is what we are doing.

I. Conclusion

We all know there is no greater legacy that has been passed on to us than the health care system.

Given the stakes and the interests, controversy concerning its future is natural. Indeed, silence and indifference would be the most worrisome signal of all.

But if we, like our forebears, are to come together and, in the end, also make the right decision, we must be guided, I believe, by some fundamental truths.

Co-operation and collaboration among all of us is not a nicety. It is a necessity. We will only reach a respectable outcome if we respect one another.

As I have made clear today, I believe it is essential that as we go through this period of difficult change, we be guided by a larger vision.

This vision will ensure that the short-term decisions we make meet the longer term needs of the nation, that we are not working at cross purposes, that as we preserve what we inherited from the past, we are also preparing for a better future.

And just as we must be careful and deliberate in our approach, the steps we take will only be right if the creativity and boldness of a great national project is there.

I believe, that, in the end, what matters is the attitude we bring. If we are frozen by fear, we will not progress.

If we believe decline and decay of medicare is inevitable, then that will surely come to pass.

But where is it written that we must fail? After all, if we stand back from daily headlines, it is very clear how great our strengths are. Our health care system *is* fundamentally sound.

The resources we have devoted to it are substantial by any historical or global standard. The expertise, the excellence of our health care providers are first class. So much of the world wants what we have.

We know the ways to move forward. I believe we also have the will.

Now is not a time to choreograph decline. It is a time to collaborate on improvement.

This is not only about the health of our people, it is also about the *economic* health of our country.

To fail to plan now to modernize medicare – to expand it and to improve it – would be an economic error. To not invest in our children, or in research, better evidence and information, would be an economic mistake. To not base our vision of the future on good health beyond the health care system would be to forego tremendous economic potential.

The fact is, our health system is one of the greatest economic assets we have. We fail to improve it at great cost. A modernized and improved health system is in the *strategic national interest* of this country. We must approach it accordingly, not simply as a social program, but as a competitive advantage.

But in the end, this is not simply about a system. It is about our soul. It is about the choice we have made to see health as a matter of public good, not personal circumstance.

It is an affirmation of the view that in a civil society, whatever else fate throws in our way, illness can never be a reason to force our fellow citizens to stand alone in the cold.

That understanding, that expression of collective will, has been entrusted to us to carry forward in our time, as the previous generation did in theirs. It is a trust we dare not betray. It is a trust we shall honour.

Thank you.

